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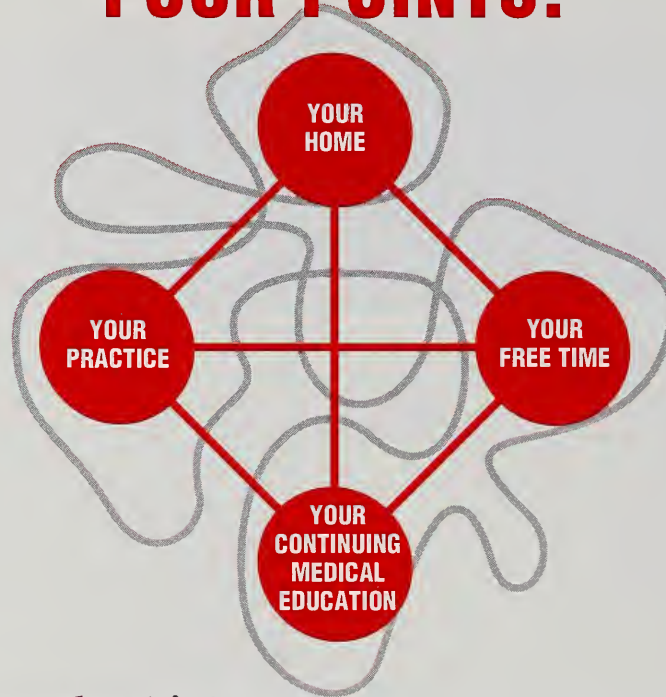
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Easing Troubled Minds Isn't Getting Any Easier

Charles R. Meyer, M.D.

Psychiatry just don't get no respect. The Dangerfield line seems justified when you survey Hollywood's treatment of the mental health profession—"One Flew Over the Cuckoo's Nest," "What About Bob," "The Bob Newhart Show"—where patients are strange and psychiatrists are stranger. Like many fear-provoking topics, mental health is a field ripe for comedy, black and otherwise. Many in the profession would say they also get no respect from managed care. Long stays and high relapse rates make mental illnesses skeletons that HMOs would like to stuff in some remote closet. This month, *Minnesota Medicine* brings some of these issues into the open in its analysis of mental health in our state.

We begin with the dramatic journey of St. Paul psychiatrist Karen Ta, M.D., who as a child escaped Vietnam under gunfire and today cares for refugees and immigrants at St. Paul-Ramsey's Psychiatry Clinic. Next, our cover stories gauge the tension between mental health and managed care and describe the fast-growing field of psychopharmacology. We also feature articles on psychoanalysis and cluster housing for the mentally ill.

Overall, we see a profession struggling with some of the same therapeutic and financial issues besetting the rest of medicine, but with some problems unique to mental health. Like other medical specialties, psychiatry continues to refine its therapy, including new psychotropic drugs and changes in the role of electroconvulsive therapy and institutionalization. Like most of medicine, mental health has had to react to limitations in patient access, utilization review, use of nonphysician health professionals, and shifts to outpatient set-



"Mental health care providers in the United States have seen managed care behavioral health firms sprout like fungi after the rain."

tings for all but the most intensive treatment. Mental health care providers in the United States have seen managed care behavioral health firms sprout like fungi after the rain. As of January 1995, proprietary managed care companies, like Human Affairs International, MEDCO Behavioral Care, and Value Behavioral Health, covered about 108 million Americans.

Unlike other medical fields, psychiatry must cope with soft diagnoses and slippery outcomes, making guideline development tricky. More than most specialties, chronicity is the standard and recidivism the norm. And then there's the Dangerfield factor—mental health care, particularly in non-Minnesota America, has been an uncomfortable add-on to most benefits packages. It's expensive, and it carries a stigma.

Paradoxically, the same costs that

nearly bankrupted the newly emerging Physicians Health Plan in the late '70s are seen by proprietary firms in other parts of the country as opportunity. The gold to be mined in the mental health hills lies in trimming inpatient care and minimizing the services of expensive providers. This threatens professional autonomy and even professional perpetuation. One study estimated that if all mental health were delivered through risk-contracted, HMO-like plans, the nation's need for psychiatrists would drop from 35,163 to 9,451. Talk about paranoia-producing prognostications!

So where's it all heading? As usual, Minnesota's health reality is the rest of the country's "Star Trek." The profits being squeezed out of systems elsewhere by proprietary firms is money long since pruned from Minnesota budgets. The "carve-out" strategy starting up elsewhere blossomed here 20 years ago and has already gone through numerous iterations. Yet as our articles attest, Minnesota's mental health care is neither static nor trouble-free. The cards are still shuffling; the anxieties still brewing. Large, integrated provider groups contracting with large, integrated payers looks like the structure of the future.

However the mental health system evolves, we need it to be patient-friendly. Large, integrated organizations with sleek guidelines mean nothing if they neglect the needs of the mentally ill. We must have an accessible, affordable place to send patients who need mental health care. We must treat the depressed and thought-disordered with the same dispatch with which we treat patients suffering infarction or stroke. Only then will "managed" mental health care earn our respect. **MM**

INNER SANCTUM

Once a refugee herself, psychiatrist Karen Ta, M.D., is well equipped to help refugees find peace of mind.

She never got to say goodbye. For Karen Ta, it was one of the hardest things about leaving her home in Vietnam 16 years ago—not being able to tell even her closest friends and relatives that she was never coming back. As far as everyone knew, she and her family were simply going to the countryside for the day. They couldn't risk telling anyone that their plan was to escape the country or that their actual destination was the sea. It would be a day spent not at leisure, but aboard a crowded boat full of people fleeing the gunfire of the Vietnamese Coast Guard in pursuit of the freedom they had lost the day Saigon fell.

As a young girl in Vietnam, Ta never dreamed that one day she would be a doctor, much less a psychiatrist, practicing in the United States. Nor did she imagine that her own experiences would be so valuable in helping her to treat immigrants and refugees in a faraway place called Minnesota. Her background nevertheless serves her well in her current staff position in the Psychiatry Clinic at St. Paul-Ramsey Medical Center, where she has developed a special interest in cultural psychiatry.

Ta credits Jim Jaranson, M.D., staff psychiatrist at Ramsey, and Joseph Westermeyer, M.D., now chair of the Psychiatry Department at the Veterans Affairs Medical Center, with fostering her interest in cultural psychiatry during her days in medical school at the University of Minnesota. "I felt that with my ethnic background, I could somewhat relate to the experience of the refugees and immigrants who came to Ramsey Clinic. Because I can speak Vietnamese, I thought I could probably help in that area, too,"

recalls Ta, who also has a strong interest in meeting people of other cultures. "Even when I take care of American patients, that is a cross-cultural experience for me," she says with a smile.

Along with treating a broad spectrum of patients

in the hospital's psychiatry clinic, Ta also works part time with Ramsey's International Health Service, performing psychiatric evaluations of patients and assessing their need for ongoing therapy. The clinic provides medical and psychiatric care to patients from around the world, including Cambodians, Laotians, Hmong, Vietnamese, Russians, Ethiopians, Cubans, and Central Americans.

Often, patients at the International Clinic are suffering from posttraumatic stress disorder resulting from experiences they had either while living in their native country or during an escape, Ta explains. Others are victims of depression related to the loss of or separation from family members, or to difficulties adapting to a new culture, overcoming language barriers, and having to learn a new way of life in the United States.

In working with patients from different cultures, Ta relies on interpreters not only to bridge the language barrier, but also to provide cultural interpretations of what the patient is conveying. "I need to know what is 'normal' in that particular culture," Ta says. "Is the way the patient is interacting or dressed considered normal for their culture?" Interpreters are familiar with both the language and the cultural nuances.

First-hand Experience

Ta grew up in a military compound in Saigon, where her father, a pharmacist, worked for the South Vietnamese army. "Since we didn't live in the countryside, I didn't experience the war much," Ta says. "But in 1968, they started bombing nearby our home. I remember running to hide underneath fur-

PHOTOGRAPH BY BRUCE BAIRD



niture and seeing trucks carrying dead soldiers." She was only 13 when the city fell to the North Vietnamese in 1975.

Within a month, Ta's father was forced by the new government to go to "re-education camp" because of his affiliation with the South Vietnamese military. He was told he would be there three days, but in reality it was three years of hard labor and malnutrition, says Ta. "The hardest part for the family was the uncertainty—not knowing when he would be back home," Ta recalls.

The rest of the family faced tremendous discrimination and limited opportunities for education or work. Any dreams Ta had of pursuing higher education disappeared. The best she and her brothers and sister could hope for were factory jobs after high school.

Then, in 1979, the family escaped Vietnam. Ta counts her family lucky to have spent only four days at sea before they were rescued by oil-rig workers off

the coast of Malaysia. "We were not very well prepared for the trip. By the end of the fourth day, we were running out of food and water, and my younger brother, who was 10, was getting very weak."

Ta spent the next year in a refugee camp in Malaysia, working to improve her English in preparation for coming to the United States. Although the family had relatives in the warmer states of California and Texas, it was a great aunt living in Minnesota who sponsored their immigration to the United States in 1980. Ta was 18 years old when she arrived in Minneapolis—the end of a long, hard journey from the tropics of Southeast Asia, to a climate she laughingly describes as "quite cold."

Eager to restart her education, Ta finished her last two years of high school at Southwest High in Minneapolis and entered the Institute of Technology at the University of Minnesota in 1982. Soon her interest turned from engineering to medicine, however, because it was "more people oriented," she says. Ta completed her undergraduate degree in genetics and cell biology and graduated from the university's medical school in 1990.

Multidisciplinary Team Approach to Treatment

It was the interdisciplinary approach to treating patients that attracted Ta to the field of psychiatry, she recalls. She particularly enjoys caring for patients as part of a team that includes not only

KAREN TA continued on page 56

By Katie M. Colón



ILLUSTRATION BY KRISTINA SWARNER

My secret

Name Withheld

I have a confession to make. I am a fourth-year medical student with a dark secret: bulimia. I am only able to write this because my name does not appear above this article.

When I planned on writing a firsthand account of mental health services available to medical students, I thought telling my story would be easy. Ever since childhood I have had an eating disorder. During college my symptoms were quiescent, but the stresses involved in beginning medical school proved too much for me. My insecurities returned with a vengeance, and I felt as if I were completely out of control. As I wrote, I realized I could not just write a factual account of my experiences. Although some of the mental health resources were very helpful, I had learned that even in medicine there is a not-always-subtle bias against mental illness.

My school has a peer support system, meant to

serve as the first line of treatment. A peer support team member, trained in eliciting information, performing triage, and providing advice and referrals, is on call 24 hours a day, but the hotline averages fewer than one call per month. I did not call for the same reason I suspect other students do not call: no matter how sensitive and well trained, peer support members are still just fellow medical students, and I could not bare my soul to a classmate.

Instead, I went to student health, where I easily made an appointment and was assured of absolute confidentiality. The physician performed a complete physical examination, discussed my difficulties with me, and provided referrals to a nutritionist and a psychologist. A workup ruled out lipid or electrolyte abnormalities. Under the student health plan, I was seen by a psychologist weekly for two months and then was referred to a

private therapist. The services were all covered by the student health plan.

The program sounds ideal, but the reality was far different. I was fortunate to begin having difficulties during my first year, when I could leave school for an hour without asking a resident's permission. But student health is open only during business hours, and the sign on the door tells students to take their problems to the hospital emergency department at their own expense on nights, weekends, or university holidays. The schedule of student health services is dictated by the undergraduate calendar. The university virtually shuts down at several points throughout the year, leaving graduate and professional students without vital support systems. I was asked not to attend my school's eating disorder support group, which meets during the day, because missing sessions as a result of my hectic schedule might disrupt the group. Once I left student health, I discovered that my health insurance covered less than half of my therapist's reasonable fee, for only 20 sessions per year.

These overt difficulties were overshadowed by the ubiquitous hidden biases I observed to exist against mental disorders. There is a widespread misunderstanding and mistrust of mental illness in our culture, and the medical profession is not nearly as enlightened as we would like to believe. I was horrified, for example, to find that many medical schools and residency programs ask applicants if they have ever received counseling. One prominent school's application reads: "Have you ever ... been suspended ... been expelled ... been indicted for or convicted of a felony ... or received counseling or psychotherapy?" The message to applicants came through loud and clear.

I wonder why our profession still draws a distinction between physical and psychological disorders. I wonder why a disorder affecting an estimated 18 percent¹ of college women in this country is such a secret. I wonder how many of my classmates have eating disorders or suffer from depression or anxieties they cannot share. It is not unusual to find a group of medical students avidly

discussing each other's symptoms; even such personal subjects as urinary tract infections are no longer taboo. We learn to draw blood, to auscultate, even to perform breast examinations on each other. Why is it, then, when I am asked where I go Wednesday evenings that I cannot answer? I say I have a doctor's appointment or a meeting, but I never dare to tell the truth.

Sadly, I realize I hold similar stereotypic attitudes. When I learned that a classmate was hospitalized for mania, I questioned whether she could finish medical school and then hated myself for my hypocrisy. I kept my secret because I am ashamed. I have internalized the societal view that mental illness is a character flaw, and I feel I should be able to control my appetite, lose weight, and cease obsessing about my appearance. I can stay up all night studying; why is it so difficult to eat only when I am hungry?

The shame is only reinforced by listening to students and even professors joke about eating disorders and mental illness, referring to a thin classmate as anorexic and speaking with disgust about overweight patients. How much easier it would be to explain a physical ailment! A diabetic could scrub out of the operating room every four hours for a glass of juice or a snack, but I do not feel able to explain why, after 10 hours of going without food, holding retractors, I feel desperate, panicked, and prone to binge.

I cannot explain why even to myself. Thus, my condition remains my secret, shared only with my closest friends. And when I am asked during residency interviews to name my greatest flaw, I will lie.

MM

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Foster DW. Anorexia nervosa and bulimia. In: Isselbacher KJ, Martin JB, Braunwald E, et al., eds. *Harrison's principles of internal medicine*. 13th ed. New York, NY: McGraw-Hill Inc, 1994:452-5.

Psychiatrists are
feeling anxious
about their role under
managed care.

Perhaps one of the clearest demonstrations of the debate managed care has provoked among mental health professionals occurred last March in the American Psychiatric Association's presidential election.

Running on one platform was Steven Sharfstein, M.D., a Maryland psychiatrist who encouraged the APA's 39,000 members to accept managed care and work with it. On another was Harold Eist, M.D., also from Maryland, whose views on the subject boil down to this: managed care is inherently flawed, and psychiatrists should never accept it.

In a hotly contested race, Eist garnered 51.2 percent of the vote to become

Psychiatry and Managed Care: UNDER ANALYSIS\$



By J.P. Miller

president-elect of the country's largest mental health professional society. Though considered extreme by many Minnesota psychiatrists, Eist fits easily into a society clearly uncomfortable with managed care. Consider the APA's managed care hotline, which fields psychiatrists' calls about the most egregious examples of managed care's problems. Then there's the society's professional journal, *Psychiatric News*, which rarely publishes an issue without an article on the topic. There's also a committee charged with

exploring ethical issues created by managed care.

Eist, according to many, has simply put a voice to the frustrations psychiatrists and mental health professionals are feeling as managed care becomes a dominant force in the estimated \$20 billion a year mental health industry.

“Sharfstein was viewed as a moderate, and to most [psychiatrists] his views seemed appropriate,” says Deane Manolis, M.D., an independent Minneapolis psychiatrist. “But there’s a lot of consternation in other parts of the country over managed care. A lot of psychiatrists are running scared and feeling like they are not able to take care of their patients as they see fit. I think [Eist’s election] represented that.”

Managed care is still new, if not foreign, to physicians throughout much of the country, but Minnesota’s mental health professionals have had almost two decades to get used to the idea. One of the country’s first managed care organizations, the now-defunct Twin Cities-based Physicians Health Plan, was nearly bankrupted in the late 1970s by its enrollees’ high utilization of mental health and chemical dependency benefits. Out of those troubles was born the Metropolitan Clinic of Counseling, one of the nation’s first so-called



ILLUSTRATION BY ALAN MAZZETTI

“There’s a lot of consternation over managed care. Psychiatrists feel they are not able to take care of their patients as they see fit.”

—DEANE MANOLIS, M.D.



carve-out mental health organizations (see sidebar, this page). MCC still provides care within the Twin Cities area.

Though many Minnesota mental health care providers say they've learned to live with managed care, it's still a hot-button topic. As in other states, Minnesota has its share of psychiatrists and other mental health care providers who say managed care can only have a detrimental effect on patient health. And among those who have accepted it, there's growing debate about what type of managed care best serves patients' needs and what shape managed care should take as it evolves.

The result is an uneasy group of mental health professionals—psychiatrists, psychologists, psychiatric nurses, and social workers—focusing their skills of analysis on themselves, their identity, their activities, and ultimately, their care of patients, as managed care becomes more deeply embedded in our

medical culture.

"The main message is that there's a lot of confusion out there over managed care and its practices," says Lee Beecher, M.D., a Minneapolis psychiatrist who practices independently and also is a policymaker for Preferred One, a Twin Cities managed care organization with more than 500,000 enrollees. "Most of the complaints and anxieties have to do with the loss of autonomy and place in the community. [Although] that doesn't have to occur when you apply the notion of managed care."

Still, Beecher concedes, "I, myself, have a mixed view of this as a whole."

Adds Jim Hermanson, M.S.W., executive director of Rochester's Zumbro Valley Mental Health Center, "The shake-out is going to be scary. We're waiting to see what role psychiatrists are going to play in the community as managed care gets going."

THE MANAGED CARE MODEL

The managed care approach to mental health is difficult to pin down because it comes in various shapes and forms. Even Mike Trangle, M.D., executive director of Allina's mental health services, sighs in frustration. "We have so many different plans," he says.

Allina serves as a good example of how varied managed mental health care can be, even within one organization. Its Medica

health plan contracts with United Behavioral Systems, a carve-out organization owned by Minnetonka-based United HealthCare Corporation, to provide mental health care for enrollees at UBS's nine Twin Cities locations. Enrollees in other plans may obtain services there, from independent psychiatrists, or from Allina's own mental health teams of psychologists, nurses, and psychiatrists. "It all depends on the plan they've selected," says Trangle, noting that mental health benefits rarely play a role in enrollees' plan selection.

Other Twin Cities managed care health systems take varying approaches to providing mental health care. Park Nicollet, for example, uses an integrated model, according to Greg Winkel, an operations administrator and licensed social worker. Enrollees see mental health teams located in Park Nicollet clinics around the Twin Cities. The teams, says Winkel, include psychiatrists, psychologists, nurses, and social workers.

In contrast, Fairview Health System, one of Minnesota's largest providers of mental health care, takes a more hybrid approach. In January 1995, Fairview began contracting out almost all of its mental health care services to a network of Twin Cities providers that includes psychiatrists, psychologists, and nurses. Psychiatrist Ron Groat, M.D., an independent practitioner in Minneapolis, is president of the new network, Behavioral Healthcare Providers. "This approach combines the best of both worlds," says Groat, noting that psychiatrists in the network can still practice independently, but they have access to the resources of a large health care organization.

Despite their differences, most managed care organizations have similar philosophies when it comes to actually delivering care, according to Manolis and other providers. "The goal is crisis resolution and getting things settled down. In managed care there is little long-

CARVE-OUT

The term "carve-out" describes clinics that contract with third-party insurers to provide mental health care on a capitated basis, according to the American Psychiatric Association. Because of their specialty in mental health and because the clinics are typically housed in separate facilities, the clinics and those who use them are said to "carve out" mental health care from other services provided. As with any capitated arrangement, the financial risk of providing care is transferred to the organization providing the actual care.

term treatment, none of the weekly visits month after month, year after year. Managed care is much more problem focused and active," Manolis says.

Hallmarks of the managed care approach to mental health also include limitations on coverage, an emphasis on drugs rather than cognitive therapy, and the use of psychologists and social workers to assess patients' health initially, according to Art Caplan, Ph.D., director of the Center for Bioethics at the University of Pennsylvania.

A study published in the October 1993 *American Journal of Psychiatry* found that half of all patients with mental health coverage were restricted to hospital stays of 30 to 60 days per year, and maximum lifetime expenditures for mental health care were also imposed on patients. Researchers found no corollary restrictions for physical ailments in the health plans studied.

AT THE HEART OF THE PROBLEM

Mental health care providers' concerns have grown in step with managed care. In 1976, about 6 million Amer-

icans obtained health care through health maintenance organizations. By 1994, the last year for which figures are available, that number had jumped to 50.4 million. Today, no region of the country remains isolated from managed care entities, says Manolis, who is often asked to speak to professional organizations in areas where managed care is relatively new.

At the heart of most providers' complaints is this issue: Is mental health a square peg being forced into the round hole of managed care? In Minnesota and across the nation, mental health care providers have achieved little consensus in answering that question.

Eist's election is only one indicator of the ambiguity. In Rhode Island earlier this year, complaints by disgruntled mental health providers prompted the state's health department to propose banning Minnesota-based United Behavioral Systems from providing services at its clinics in the state. The health department accused UBS

PSYCHIATRY continued on page 58

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Such as hospital policies.



RIDING THE BRAIN *W*AVE BIOLOGICAL

*B*iology clearly offers the only comprehensive scientific basis for psychiatry, just as it does for the rest of medicine.”

So wrote Samuel B. Guze, head of the Department of Psychiatry at Washington University, in a 1989 article for *Psychological Medicine*. He went on to say psychiatrists cannot ignore culture, philosophy, ethics, and religion as they try to understand psychiatric disorders. But, like all physicians, psychiatrists treat living, reacting, thinking individuals who are suffering from a variety of disorders. “To understand and help them,” Guze wrote, “psychiatry must turn increasingly to biological science.”

And it has. Psychopharmacology, also referred to as biological psychiatry, blends psychiatry and biology to treat mental disorders, often with a combination of drugs and psychotherapy. While some critics say drugs are merely a “quick fix,” proponents argue that medications are not only an acceptable treatment tool, in many cases, they are vital to recovery.

Before the discovery of drugs to treat mental disorders, psychiatry was almost completely dominated by psychoanalysts. Since the discovery of psychiatric medications some 40 years ago, however, research has resulted in a variety of medications that effectively treat everything from depression and

BY VICKI *S*TAVIG



Drugs are fast replacing psychotherapy for treating mental illness, but is psychopharmacology just a quick fix?

anxiety to schizophrenia and obsessive-compulsive disorders.

Drugs have become an important tool in treating mental disorders, says Frederick Ferron, M.D., medical director of Fairview Behavioral Services, which offers a wide variety of community-based and hospital-based programs for mentally ill and chemically dependent patients of all ages. That does not, he adds, in any way devalue the role of psychotherapy. Good psychiatry, he says, involves both medication and therapy.

As director of the psychiatry residency program at the Veterans Affairs Medical Center in Minneapolis, Charles Dean, M.D., has been tracking the rise of psychopharmacology. "The [psychiatric] training program still requires us to get experience and training in psychotherapy, but more and more, the focus is on biology, so you have to learn about biological ways of studying illnesses," says Dean.

"Therapy gives us some additional tools," he's quick to point out. "The effects of learning carry over better than drugs, but it's slower. In some instances, the patient might be better off with cognitive therapy than with antidepressants over a 12-month period. Clearly, there is still a need for therapy.

You can't give a patient a drug and not pay attention to anything else."

The Making of a Psychopharmacologist

Psychopharmacology is in its infancy but is fast gaining recognition as a valuable method of treatment, says Faruk Abuzzahab, M.D., a psychopharmacologist with Clinical Psychopharmacology Consultants in Minneapolis and a University of Minnesota faculty member. It is being practiced by a vast majority of psychiatrists who find it very effective and less time-consuming than therapy alone. "Almost all psychiatrists now practice psychopharmacology," he says.

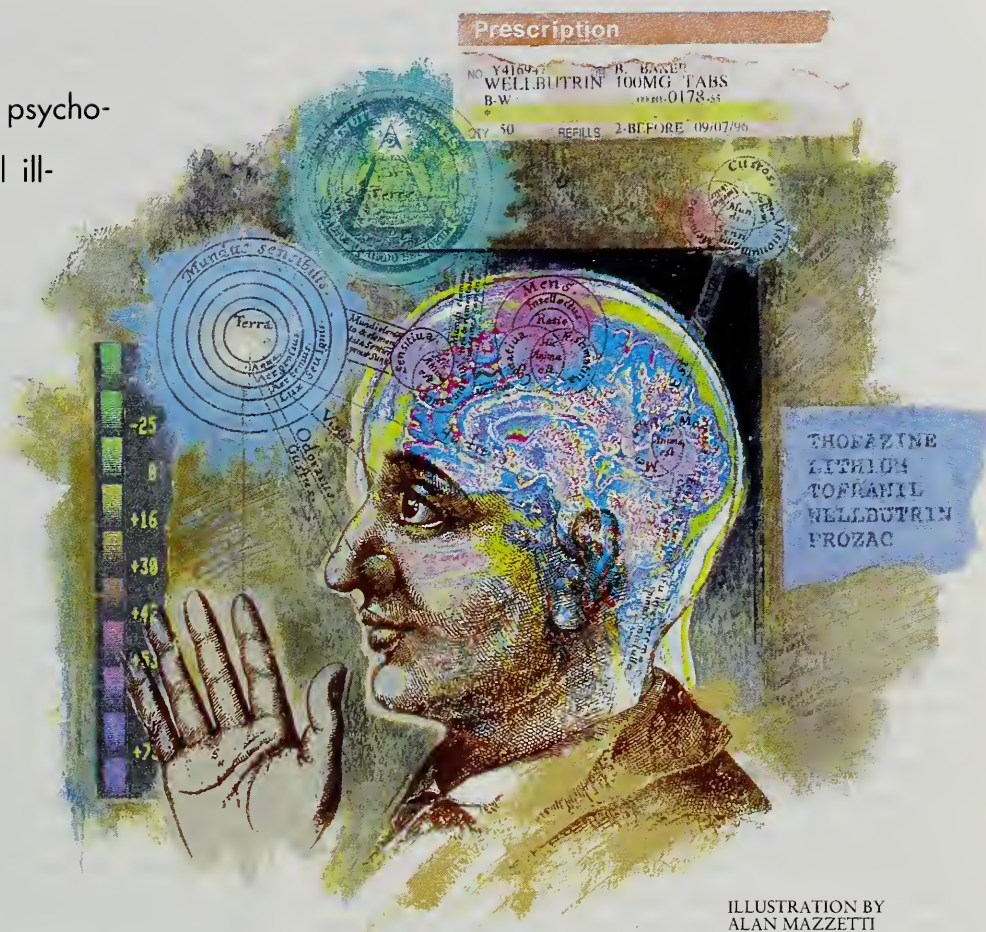


ILLUSTRATION BY
ALAN MAZZETTI

While the term "psychopharmacologist" can apply to any psychiatrist who prescribes drugs, it is generally used only by those who, like Abuzzahab, have studied the field extensively. Abuzzahab likens the new field to obstetrics. "It used to be that all doctors delivered babies," he says. "Now they specialize."

Many psychiatrists turn to seminars, workshops, and continuing education to keep abreast of research, diagnoses, available medications, dosages, and possible side effects. Research fellowships in psychopharmacology now are offered at several academic institutions throughout the country, and the University of Minnesota, says Ferron, "is well-known for providing trainees with a good background in psychopharmacology."

Says Dean, "Anyone who goes through psychiatric training studies the pharmacology of drugs: how to use them, their risks, and their benefits. Psychopharmacology is a specialized area. It's an extension and intensification of the training in a four-year residency program."

Much of the training in psychopharmacology is closely related to neurology, involving the study of many of the same neurotransmitters, receptors, and drug interactions. "Neurology and psychopharmacology are very, very close," says Abuzzahab. "In fact, there is now a new field called neuropsychopharmacology."

Many patients have psychiatric complications of neurological diseases, such as strokes and Huntington disease, and are treated by both a neurologist and a psychopharmacologist, Dean explains. For example, 40 percent of Parkinson patients have depression problems, and Huntington sufferers can have psychotic problems.

"Psychopharmacologists wind up treating people who have primarily a neurological condition but have a psychiatric condition, as well," says Dean.

Adds Ferron, "Where the two fields really interface is with diseases like Alzheimer's, where a patient clearly has a foot in each camp."

The Discovery of Psychotropic Medications

With the exception of shock treatment and prefrontal lobotomies, no remedies existed for treating serious mental illnesses like schizophrenia until Thorazine was discovered in the 1950s, says Dean.

Thorazine, the first effective psychotropic drug, was discovered by accident. "They were looking at it essentially as something that might be helpful in anesthesia and noticed it sedated people without putting them to sleep. Psychiatrists in France started using it with psychotic patients; it seemed to suppress psychotic symptoms like paranoid thinking and delusions," Dean explains.

At the same time, work on lithium, a medication for mania, and Tofranil, an antidepressant, was underway. "The discovery of these medications set off a big search as to how these drugs worked on transmitters and other chemicals in the brain," says Dean. "Researchers then began working backwards from the drug to the biochemistry of the drug, to the biochemistry of the illness, but not very successfully."

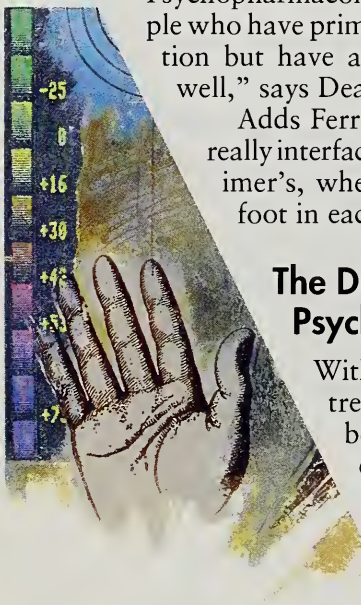
Diagnosis and Treatment

The advent of these drugs has armed psychiatrists with numerous new weapons for combating the many psychiatric problems experienced by large portions of the population. The five most commonly encountered by internists are anxiety disorders, dementia, delirium, depression, and alcohol or substance dependence, according to William Anthony Callahan Jr., M.D., who recently spoke to members of the American College of Physicians about mental disorders. In addition, there is a prevalence of mental disorders in persons age 65 and older. "Anxiety is at the top of the list; schizophrenia is very minimal," he says.

Callahan, director of Fairview Adult & Senior Behavioral Services and a physician with Clinical Psychopharmacology Consultants, P.A., says psychiatry must become more like the rest of medicine and use diagnostic criteria to determine both the problem and the treatment. Some medical conditions—including myocardial infarction, hypoglycemia, multiple sclerosis, asthma, anemia, systemic lupus erythematosus, and withdrawal syndromes—can simulate anxiety. Medical conditions associated with geriatric depression include hypothyroidism and hyperthyroidism, Parkinson and Huntington diseases, hepatitis, congestive heart failure, and Lyme disease, says Callahan, who specializes in geriatric psychiatry.

"Many general medical conditions can have mental symptoms," he says. Consequently, determining the underlying cause of what appears to be a mental health problem can be difficult, and so can selecting the most appropriate treatment.

"You have to keep an open mind, not just be focused on one type of treatment," says psychiatrist Tom



Dredge Jr., M.D., who specializes in adult psychiatry with a focus on the severely mentally ill. "If the primary symptoms revolve around depression, you look at genetic factors, family history, prior treatments, and external factors, such as relationships. You have to adequately assess to see how much of the problem might be connected to biochemical issues versus stress issues or learned issues. There are many variables, and treatment should be tailored to those variables. You have to be thorough in your assessment of what factors are involved."

"Psychotherapy can be a great benefit in treating depression," says Ferron of Fairview Behavioral Services. "On the other hand, in schizophrenia, where a person

"The effects of learning
carry over better than
drugs, but it's slower."

—CHARLES DEAN, M.D.

is having active delusions, you would want to be cautious with psychotherapy. Medications would be of primary importance here, because you first want to help with the person's thinking—get that organized."

Ferron also uses an example of a patient

with very low thyroid. The patient is feeling sluggish and "down" and has other symptoms that make him appear to be depressed. "He might be depressed anyway," says Ferron, "but the low thyroid is making it worse. We treat the low thyroid and see how it affects the depression."

Although medications have been invaluable in treating certain mental disorders, experts don't see them as a panacea. Rather, they view drugs as another tool in treating mental disorders. "When patients come to see a psychopharmacologist, it's not, 'Hello, how are you, here's the Prozac,'" says Abuzzahab. "We talk about their symptoms, their major disappointments. There is some supportive psychotherapy to help them understand the issue, the behavior."

Clearly, some type of therapy is beneficial in providing the patient with coping mechanisms that drugs can't offer. Dean of the Minneapolis VAMC cites the case of a patient suffering from depression who was given electroconvulsive treatment. The treatment worked well, he says, but when the patient returned home, he was caught in the middle of an ongoing conflict between his

wife and his mother.

"You could see him regress as these two very powerful women were fighting over him," says Dean. "So drugs have limitations; antidepressants have limitations. We also have to look at the social and cultural issues involved. There are clear limits on what drugs can do. What happens to patients when they go home? The relapse rates for people who take drugs and go home to unhealthy environments are higher than when they don't take drugs and go home to a reasonably stable home environment.

"Some of these situations can be more powerful than the drugs," says Dean. "People are sadly mistaken if they think drugs will help them overcome all manner of adversity. We're in the middle of a dramatic socioeconomic crisis out there. As the social scene becomes more disorganized, psychiatry turns more inward to biology. The social treatment can get lost as we treat the biological."

Says Dredge, "I can put a person on medication and it will be quite helpful, but when the patient stops taking the medication, he might go back to the behavior again. With therapy, he might be able to use the skills he learns; drug therapy can sometimes be reduced or eliminated, and the patient can continue with just psychotherapy.

"Medications can be very effective and make a major difference," Dredge says. "For example, medication is quite significant for treating schizophrenia and for major depressions, especially those that are genetically determined. Many mental illnesses require a combination of therapy and medication."

Scientific Advances

Ongoing research and new technologies are improving psychopharmacologists' understanding of the causes of some mental disorders and the effects of medication, says Ferron. One important new tool is positron emission tomography (PET), which maps the anatomy and activity of the brain and allows psychopharmacologists to see how drugs affect the brain. PET scans can show, for example, which receptors are blocked and how blood flow is affected in patients who are taking antipsychotics.

Much work needs to be done, however, in determining the cause of most mental disorders. "There is no definite proof of a specific biologic cause for any disorder

der," Dean says. "There are hundreds of studies, for example, that indicate an association between schizophrenia and changes in brain structure, but I don't know anyone who could prove that neurotransmitter X or structure change Y is the cause. If I could say that, I would have a Nobel Prize and \$50,000 tax-free."

Even without a full understanding of the causes of mental illness, researchers are working to improve existing drugs and to develop new and better drugs, giving patients and psychopharmacologists more options for treatment, particularly for schizophrenia and depression.

"We now have a much wider choice of effective medications," says Dredge. "Quite a number are in the process of being studied and will probably be on the market in the next few years."

The new drugs, says Dean, have fewer side effects, "but the primary therapeutic results are no better, except in a few cases, such as clozapine [used to treat schizophrenia]." The most significant improvement is the reduction of side effects, which can range from blurred vision, dry mouth, or constipation, to a dangerous lowering of the white blood cell count and involuntary movements, particularly of the face, trunk, arms, and legs. Fewer side effects mean patients are more likely to continue with the drug treatment, reducing the possibility of relapse.

The new drugs also are safer. For example, you can't overdose with Prozac. "It's virtually impossible," says Abuzzahab. "You can't play Marilyn Monroe. You can take 200 capsules of Prozac, and all you'll do is lose \$400."

The Price Tag

Often, however, increased safety and decreased side effects boost a medication's price tag. The growing predominance of managed care has made that a particular concern. Some managed health care plans restrict access to certain drugs because of their cost. "You can get them, but you have to jump through hoops," Dean says.

"The way dollars are being watched these days," says Ferron, "we're going to have to look at costs of treatment. If a drug is more costly but has a side-effect profile that causes fewer medical problems, maybe it will look like a reasonably good alternative. I think what managed care companies are saying is there are some parts of drug A that will save dollars down the road. Even though it's more costly up-front, will the person be more willing to take the drug and stay out of the hospital? It's not just comparing the cost of drug A with drug B, but looking at the whole picture."

In fact, when they look at the bigger picture, many health maintenance organizations are finding medica-

tion to be a cost-effective alternative to psychotherapy. "Psychotherapy is very time-consuming," says Dean. "A psychopharmacologist can see six people in one hour as opposed to a psychotherapist spending 50 minutes with one patient."

"It is more cost-effective to treat depression with drugs," adds Abuzzahab, "because therapy takes more time and is more expensive. If we take 100 people with depression and put them on Prozac, 80 percent will improve in four to five weeks, and we don't have to see them again for six months."

"The outcome with medication is the same as with therapy, so HMOs are saying, 'why send a patient to a very expensive, over-trained therapist when we can have the same outcome for one-third the cost?'" says Abuzzahab. "Whoever pays the piper calls the tune. Psychotherapy has been moved out of the main." MM

Vicki Stavig is a free-lance writer residing in Bloomington, Minnesota.

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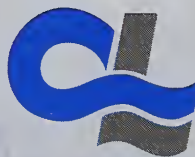
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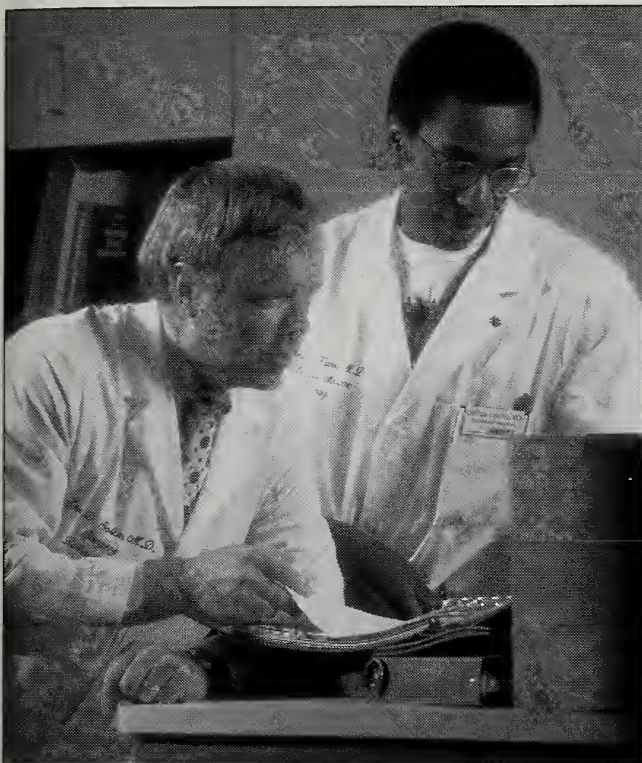
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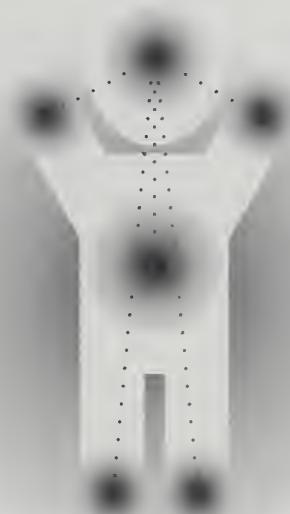


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Psychoanalysis: A Cure for Our Time

*Does the new psychiatric order leave room—
or dollars—for psychoanalytic therapy?*

Willem Dieperink, M.D.

Psychoanalysis is often depicted as something arcane and mysterious. Yet psychoanalysis has existed for 100 years and continues to attract widespread interest, mostly from outside the field of medicine. Psychoanalysis is a form of psychotherapy, a theory of the mind, and a profession. In therapy, the psychoanalyst creates a situation with the patient that allows insight into and cure of mental disorders. This process is complex and involves a particular kind of partnership in which the patient's faulty adaptations of the past, causing mental disorder, are laid bare and changed. Psychoanalysis uses the profound power of the personal relationship in undoing mental pathology and creating health. It emphasizes nurture, not nature, as the origin and cure of mental disorders. Psychoanalysis requires patience and time.

Major shifts are taking place in the nation's health care system that affect psychoanalysis as a medical discipline and as a subspecialty of psychiatry. The new economic climate created by managed care makes patience and time rare commodities (see related article, page 10). In 1980, the paradigm of the nosology of mental disorders changed, as organized by the American Psychiatric Association in its "Diagnostic and Statistical Manual," edition III and later, IV. DSM III and IV revealed that the APA is no longer concerned with psychoanalytic explanations and causality. With this change, medical psychiatry forgot, almost overnight, psychoanalysis as one of the most important and helpful contributions to the understanding and treatment of disorders of the mind and human relations. One could say, "So be it; things are changing everywhere in medicine." However, the loss of psychoanalytic knowledge parallels the loss that medical practice in general is suffering—the loss of individuality of patient and doctor alike and, with that, the loss of individual care. This article describes, in a cursory way, some aspects of the clinical concepts and practice of psychoanalysis, the training and organization, and how it fits into the larger picture of mental health care.

MENTAL HEALTH AND DISORDER

Psychoanalysis conceptualizes mental health as complex and dynamic. The state of mental health is a relative state, dependent on a combination of innate, environmental, cultural, and developmental factors. Mental health is not only the absence of mental disorders, but also the ability to be a free person. Mental health includes a freedom to develop, to enjoy one's innate talents, to grow and mature, and to have productive relationships in one's family and in society.

This view of mental health contrasts with the view that mental health problems are a matter of imbalance in brain chemistry requiring psychotropic medication. This biological paradigm is predominant now in medical school teaching and, as a consequence, psychiatrists tend to prescribe medication for their patients (see related article, page 14). Many patients respond well to medication, which relieves their symptoms. However, such treatment alone does not address the individual's mental health. The restoration of mental health requires profound and intense learning in a facilitating environment. That environment is the domain of the psychoanalyst.

Psychoanalysts consider mental problems disorders of the mind that are believed to disturb the core experience of self and the relationship to others and the world. Sigmund Freud initiated the psychoanalytic theory of the cause and treatment of mental disorder in Vienna about 100 years ago. He formulated a developmental theory, based on his observations that many things can go wrong when the individual grows up. Undisturbed human emotional maturity is rare. Many practitioners since Freud have enlarged and refined these ideas.

Most mental disorders originate when the mind is immature and, therefore, vulnerable. The immature mind of the child is easily deprived of its special needs. These deprivations lead to faulty adaptations, which in later life give rise to mental symptoms and illness. For example, a child responds to pathological circumstances in his or her own way, expressing mental pain and anxiety by means of behavioral or emotional disturbance. A de-

prived child might become delinquent; a child who has to deal with the loss of a sibling or parent may become listless, passive, or show an inability to learn; a frustrated child may express his or her frustrations by means of temper tantrums; and, of course, an abused child may become aggressive and abusive. The child can be helped at this time if someone recognizes and alleviates these signs of stress. Then the child can continue to grow and develop.

Often these symptoms become chronic and manifest themselves in later life in mild to very serious forms of psychological symptoms or patterns of destructive behavior. By that time, the symptoms are usually so far removed from the original pathological influences that the individual will not recognize the origin. The patterns have become unconscious. A belief in the influence of the unconscious is commonplace in modern culture, but the power of unconscious pathological patterns is not easily understood. To master these patterns requires psychoanalytic treatment.

PSYCHOANALYSIS AS A FORM OF PSYCHOTHERAPY

Freud developed a method of therapy that is particularly suitable to treating problems that originate in childhood. The fundamental idea of psychoanalytic psychotherapy is that people are given an opportunity to resolve what was previously unresolved. In the therapeutic setting, the patient works with the psychoanalyst to recognize what the pathological patterns have been and to change them. It is an "after-education," as Freud called it, because what should have happened in childhood can now happen to an adult in the safe association with a psychoanalyst.

The child's adaptations necessitated by pathological life circumstances manifest themselves in later life in a variety of disorders, such as depressions; anxiety; phobic and obsessive disorders; eating, sexual, and relationship disorders; character, personality, and borderline disorders; psychosomatic disorders; and the psychoses. The psychoanalyst today adapts his or her treatments to patients with these types of mental disorders. If possible, the therapy takes place without the use of medication; however, it may be used if necessary, particularly with people who suffer from psychosis.

For the patient, treatment requires a personal dedication and an ability and willingness to work with the analyst for an extended period of time, usually several years. The treatment takes a long time because the focus is not just symptom relief, which often can be achieved quickly, but is, instead, the restoration of the individual's integrity and maturity.

Practical considerations of time and money tend to limit treatment. Indeed, the financial cost of psychoanalysis seems high, until one considers the enormous cost of a disorder that may be responsible for destructive relationships or an inability to work. The high cost of hospitalization, medication, and affliction with an illness must also be considered.

MISCONCEPTIONS

Misconceptions about psychoanalysis sometimes prevent people from considering it as a therapy. A common

misunderstanding of psychoanalysis is the idea that it is a static theory of Freud, who is long dead. Actually, psychoanalysis is progressing, changing, and adding to its understanding and practice as observations of new data demand. Most major cities worldwide have institutes for psychoanalysis, affiliate societies, and study groups. There are 28 accredited training institutes in the United States and several in development. Many psychoanalysts are actively involved in research, and over the last decade, the focus has been on outcomes research. A review article on the efficacy of psychoanalysis appeared in the *American Journal of Psychoanalysis* in 1991.² One important German outcomes study³ showed that people who have gone through psychoanalytic psychotherapy have much less physical disease and experience fewer hospitalizations, surgical procedures, and other health problems than people who have not gone through it, if one compares similar groups over a 10-year period. This research showed the profound cost savings of psychoanalysis and was one reason why psychoanalysis became a part of the health insurance package in Germany.

Another misconception about analysis is that it focuses on the past. Psychoanalysts do not treat the past, but, rather, the "here and now"—how past problems distort normal relationships. The focus of psychoanalysis is on the distortions the patient brings along in relationship with the analyst. By understanding and working intensively with those distortions, the patient and therapist can change them.

Another frequent misunderstanding is the notion that psychoanalysts are only interested in the individual's sexuality. Although Freud called childhood development psycho-sexual development, he never meant that in an adult sexual way, but in an infantile way. He meant "sexual" to be a general drive, a broad biopsychological drive serving the process of maturation and human relatedness.

Another misconception is the idea that psychoanalysts treat the "worried well." In fact, psychoanalysts treat people with a whole range of emotional problems, including chronic debilitating problems that often have been treated with medication, group therapy, and/or behavior modification techniques.

Finally, some people believe that psychoanalytic therapy is open-ended, when, in truth, it has a specific and defined end.

TRAINING THE PSYCHOANALYST

Clearly, a therapist who does any kind of intense psychotherapy should be well trained. Psychiatry is not an easy subject, because the mind is complex. The psychoanalyst goes through rigorous training. Most psychoanalysts are physicians who have completed a four-year psychiatric residency after medical school or have another advanced academic degree. The first part of the psychoanalytic training requires candidates to undergo analysis themselves for several years. The analyst, therefore, knows what it means to be a patient.

The other part of the training is didactic. The analyst completes a four-year program in an institute for psycho-

analysis and is supervised for many years while analyzing patients. The training takes about eight years. An examination or a paper completes the coursework. After this program, the graduate analyst can apply for certification by the Board on Professional Standards of the American Psychoanalytic Association. The work is critically evaluated, and either the graduate gets certified or is required to do further remedial analytic work.

Through this training, students become proficient in psychoanalysis and the shorter forms of dynamic psychotherapy. The years of individual supervision and the personal analysis are safeguards and quality controls for this difficult work. This education is in contrast to the fairly superficial training in psychotherapy that the psychiatrist receives. Many psychoanalysts become teachers of psychotherapy for psychiatric residency programs, but the time allotted is minimal because of the emphasis on biological psychiatry.

PSYCHOANALYSIS IN THE TWIN CITIES

Psychoanalysis has been present in all major U.S. cities since 1930 but came officially to Minnesota in 1973, when the first training psychoanalyst settled here to begin a training program as an extension of the Institute for Psychoanalysis of Chicago. A Psychoanalytic Study Group was formed as part of the American Psychoanalytic Association. The membership of this group has grown since. There are now three training analysts, seven graduate analysts, one research graduate, and 10 psy-

choanalytic candidates in different levels of training, all participating in the Institute for Psychoanalysis in Chicago, where the classes are held on Fridays and Saturdays. Since psychologists and social workers now can receive the full training, two Ph.D. psychologists have become candidates. Three candidates are also in training to become child psychoanalysts. All participants in the program are active practitioners, clinicians, and teachers in the Twin Cities. The Psychoanalytic Study Group has developed a three-year psychotherapy training program for advanced psychotherapists.

PSYCHOANALYSIS AND MEDICAL ECONOMICS

Since the development of HMOs and changes in insurance practice, reimbursement for psychoanalysis has become a problem. The reimbursement for psychoanalytic therapy has always been minuscule compared with the total cost of psychiatric and medical care, yet psychoanalysis has been widely rejected by HMOs and insurance companies. It is not difficult to understand why; psychoanalytic therapy is anathema to mass therapy, in which the bottom line is the major concern.

This rejection coincided with the change of the medical paradigm for understanding mental illness and health. The biological psychiatry paradigm suits the mass and time-limited treatments popular with cost-cutting companies. This paradigm does not necessarily require well-trained personnel who engage in a personal, confidential, and intimate relationship in which the

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stakes are high for both patient and therapist. Because of the personal, intimate contact in which the analyst becomes the target of strong feelings, both positive and negative, the analyst has to be able to react appropriately and therapeutically.

Interestingly, unhappiness with the new psychiatric order is high among patients. Psychoanalysis may continue to flourish even in a hostile insurance climate. Mental health cannot be regulated and forced into a straitjacket by drugs or by a philosophy that denies complex and personal, caring contact. The new order of mental health encourages the loss of mental health and the acceptance of illness as a way of life, which is costly, indeed. In other countries, it has been shown that psychoanalysis can play an important and cost-containing role in the total package of health care.

Psychoanalytic theories and experiences are the cornerstones of every kind of psychotherapy, except the behavior therapies. Most therapists, even if they are not analysts themselves, have learned much from psychoanalysis. Psychoanalysts could play an important and cost-containing role in the education and supervision of other therapists working in organizations. We know how costly and heartwrenching naively applied psychoanalytic knowledge can be. The furor about so-called repressed memories is a good example. Repression is a psychoanalytic theoretical phenomenon, but it often is wrongly applied to the phenomenon of suggestion. A therapist has to be well trained to detect the difference.

WHO WOULD BENEFIT FROM PSYCHOANALYSIS?

In theory, most people would benefit from psychoanalytic treatment, because everyone responds well to attentive listening by a well-trained professional who will preserve confidentiality and who has training and personal experience in the understanding and psychotherapy of emotional problems. Practical considerations pose limitations, but anyone who has either acute or chronic emotional disorders that interfere with effective functioning at home or at work would benefit. Such people are not only interested in symptomatic change, but also in fundamental psychological change for which quick fixes fail.

MM

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REFERENCES

1. Gay P. Freud: a life for our time. New York, London: W.W. Norton & Co., 1988.
2. Bachrach HM, Galatzer-Levy R, Skolnikoff A, Waldron S Jr. On the efficacy of psychoanalysis. J Am Psychoanal Assoc 1991;4:871-917.
3. Duehrssen A. Katamnestiche ergebnisse bei 1001 patienten nach analytischer psychotherapy. Z Psychosom Med Psychoanal 1972;7:2.

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2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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Cluster Housing for the Mentally Ill

The Familystyle Homes Experience

This St. Paul program allows patients with severe mental illness to live and work with as much independence as they can handle.

James Janecek, M.D.

Residential facilities for the mentally ill became a focus of attention after the de-institutionalization movement of the mid-20th century. These facilities are an important and effective source of rehabilitative services for the seriously and persistently mentally ill. Unfortunately, many single-roofed residential facilities have simply replicated the old state hospitals in that residents are cared for in a "total institution," where everything is done to and for them. While traditional residential facilities have merit, there is always a danger of encouraging institutional dependency.

This article introduces the "cluster concept" of normal, family living for the mentally ill by describing Familystyle Homes of St. Paul and the effectiveness and problems of such a program. Familystyle Homes' 10-year history indicates that traditional approaches to the housing and habilitation of the mentally ill in single-roofed facilities may not be the only, nor the best, option for this population. Historically, individuals with little family support and with pathologies serious enough to merit hospitalization rarely re-enter community living. Improving their quality of life may be most effectively—and cost-effectively—accomplished through replication of a normal living environment in which patients are provided both comprehensive services and a degree of independence through the use of clusters of separate dwelling units.

FACILITY AND PROGRAM DESCRIPTION

The shadow of a huge brewing plant on the west side of St. Paul, Minnesota, falls over a neighborhood full of unremarkable houses, but *remarkable* residents. Up and down Duke Street, people walk in ones and twos, some enjoying the weather, while others seem to look inward. The neighborhood, which hosts Familystyle Homes (FSH), is the physical expression of what might happen if a psychiatric institution were gently turned inside out, with its residents coming to rest in nearby homes. FSH is a campus of sorts, a home where residents live and work with as much independence as they are able to manage. Staff members crisscross the street, jangling keys and

greeting residents as they make their rounds. It's a place of tranquillity interrupted by the occasional crisis.

The residents come to rest at FSH because most have nowhere else to go. For some, it's the end of the line, while for many others, it represents a very real beginning. The cohort of FSH residents comes from the streets, state hospitals, and prisons. Long, intricate psychiatric résumés make their relative independence at FSH breathtaking to consider. Many residents buy and cook their own food and govern their own living units, while making frequent trips to the main facility for medications and counseling.

With 152 beds, FSH of St. Paul is the largest mental health facility in Minnesota, yet all but 21 of the residents live in housing units of five or fewer persons. The facility is based on a cluster concept that locates services in a single geographic area, in this case, a rundown neighborhood of marginal housing near downtown St. Paul. The central facility includes a traditional board and care institution with 21 beds. An additional 20 free-standing duplexes and apartments are dispersed in a two-block radius, all part of a neighborhood but forming their own community. These buildings house 131 residents.

FSH residents are virtually indistinguishable in terms of pathology from the common populations of most hospital-based psychiatric facilities, but they exhibit coping skills that set them apart. State-of-the-art medication programs combined with a high level of support enable most of FSH's residents to live with their illnesses.

REHABILITATION SERVICES

FSH has several levels of service, with placement determined by the resident's level of functioning upon admission. The central facility is the Board and Care Building, which is used for congregate dining and for housing vulnerable individuals who need 24-hour observation. Board and Care is a total care facility.

FSH's second option, Board and Lodging, includes five programs—Intensive Care, Rehabilitation, Dual Disability, Southeast Asian, and Semi-Independent Living. These programs are carried out in rehabilitated

homes within a two-block radius of the Board and Care Building. The Intensive Care Program treats residents who are seriously mentally ill but do not require 24-hour observation. The Rehabilitation Program provides services focused on seriously and persistently mentally ill individuals who are capable of coping with a greater level of independence. The Dual Disability Program is designed to meet the needs of residents with both mental illness and chemical dependency, while the Southeast Asian Program is a culturally sensitive effort to deal with mental illness in the Hmong and Vietnamese communities. The Semi-Independent Living Service (SILS) provides a less structured environment for residents who are making progress in coming to terms with their symptoms and illnesses. SILS residents are responsible for their own cooking, cleaning, and money management.

The therapeutic community that makes up FSH is designed to replicate normal living while providing supportive, round-the-clock services. Mental health workers make rounds of each unit every two hours, checking in with residents and addressing any problems that arise during the course of the day. All dwelling units consist of five or fewer beds.

A staff-facilitated Adlerian model¹⁻⁴ of family conferencing provides a governing structure for the individual units. To utilize this family conferencing model, residents must first recognize the root of their problem, which for the seriously and persistently mentally ill is emotional isolation from others. This is the foremost cause of social pathologies described as antisocial "street behaviors" and emotional withdrawal as seen in the typical person entering Familystyle Homes.

The Adlerian family conference model requires regular meetings with a staff facilitator, who strives to promote group cohesiveness and mutual assistance. The facilitator appoints a rotating group leader among the resident family unit. The staff facilitator helps the resident leader encourage group members to cooperate and to publicly disclose problems and shortcomings, helps residents understand the universal nature of most human living problems, educates residents on general standards of conduct, helps residents see themselves as helpful to others, and provides social reality testing. All of this is done under the principle of absolute equality. The staff facilitator is seen as an educational resource and not as an authoritarian leader.⁵

All residents, with the exception of the SILS participants, receive a broad array of individual and group support. The high concentration of staff and proximal psychiatric services allows profoundly challenged people to begin replicating and internalizing healthy, normal living patterns. Private housing and phone lines mean that clients do not have to identify themselves as residents of an institution, hence, they are free to interact with the community and employers on their own terms.

FSH employs 52 staff members, including a board-certified psychiatrist as full-time program director/chief executive officer, an administrator, five assistant program directors, six mental health counselors, 23 mental health care workers, and four licensed practical nurses.

The remainder of the staff are in support services, including cooks and housekeepers.

ADMISSIONS

In fiscal 1993, there were 335 admissions and readmissions to FSH, including 25 internal transfers from board and care to independent living. There were 98 first-time admissions.

The usual first-time admission to FSH is a young adult male. In 1993, 72% of admitted individuals were men. Of the 98 residents admitted, 47 were referred from hospital mental health units, 26 came from the regional treatment system, and the remainder came from detox centers, prisons, chemical dependency units, and the streets. No one is admitted without a referral from a county worker.

Contrary to popular expectation, 57% of the first-time admissions had a principal diagnosis other than schizophrenia, including major depression, depressive neurosis, and organic brain syndrome. Although 43% were diagnosed with schizophrenia, half of these individuals presented a dual diagnosis of chemical dependency. Underdiagnosis of dual disorders and consequent recidivism is one of the major challenges with this treatment modality.⁶

The underdiagnosis of dual disabilities poses a variety of problems. First, it is clear that patients with a major mental disorder and a concurrent alcohol or drug problem do not recover unless both problems are addressed. Second, it is seldom possible to tell which disorder—chemical dependency or another major mental disorder—is primary. Third, long-term recovery requires sometimes simultaneous and, at other times, alternating, approaches to both disorders.⁷

RESULTS AND DISCUSSION

Success at FSH is measured in relative terms: fewer admissions to detox, fewer exposures to the criminal justice system, fewer behavioral episodes requiring hospitalization. The objectives are modest and are targeted toward teaching residents how to live with their illnesses. As the accompanying table indicates, of 175 final discharges in fiscal year 1993, 96 FSH residents made the transition to independent living in the community.

The average length of stay for individuals placed in community living, including those in SILS, was 146 days or a little less than five months. Comparing these results with that of other programs is not easy; however, a 1990 study by the Minnesota Department of Human Services suggested that 28.7% of residents in Rule 36 Facilities (analogous to Familystyle Homes) were discharged by six months, and 71.3% were in the facilities for longer than six months.⁸

FSH residents show appreciable progress using common measures of symptom analysis. For those residents discharged to community living, their average admission Global Assessment of Functioning Scale (GAF)⁹ was 51, while their discharge GAF was 57. GAF is the standard Axis IV determination from the "Diagnostic and Statistical Manual of Mental Disorders," edition IV, pub-

lished by the American Psychiatric Association. It considers psychological, social, and occupational functioning on a hypothetical continuum of mental illness/mental health. The lowest score is zero, and the highest is 100. Lower scores suggest more pathology in symptoms and functioning.¹⁰

Average PSYSUM¹¹ was 67, while average discharge PSYSUM was 64; although the difference is statistically significant, I do not believe it is "clinically" significant. The residents' symptoms actually change very little from admission to discharge. (The Psychiatric Factors Composite Scale [PSYSUM] was developed initially by the New York State Office of Mental Health Level of Care Survey. It was subsequently edited and published by the Minnesota Department of Human Services. There are seven basic subscales. The total score can range from 32 to 160. The worse the clinical condition, the higher the score.)⁸

The data document that pathology and concomitant symptoms are not a reliable predictor of success in achieving independent living. The past 10 years at FSH have demonstrated that less esoteric indicators are much more reliable. Does the resident have an intact social support system? Is the resident complying with a medication schedule? And is the resident willing to take control of his or her own financial and occupational destiny? Many individuals who seemed doomed to a life of institutionalization because of the depth of their pathology have graduated into the community because they became willing to take responsibility for their own recovery and well-being. The community placement of these gravely disabled individuals took place in spite of their pathology.

Overall, however, end-of-year data at FSH indicate that a significant group of persistently mentally ill people return to us months and sometimes years after community placement. They are "non-fits" in the context of the broader culture and other components of the mental health system.

Our data suggest the recidivist problem of repeated admissions into and discharges out of residential facilities is directly correlated with the presence of both a psychiatric and substance abuse disorder. This is particularly true of individuals with a diagnosis of schizophrenia and chemical dependency. Surveys suggest that up to 63% of individuals with chronic schizophrenia and chemical dependency or abuse are notorious for exacerbation of symptoms, massive denial of the substance problem, and repeated hospitalizations.

Attempts to alleviate these problems with community support programs and other interventions have shown a consistent decrease in recidivism. Unfortunately, this decrease requires an enormous expenditure of money and time.¹² This should not be discouraging. Ridgley and others have pointed out that the study and treatment of seriously and persistently mentally ill with psychiatric and substance abuse disorders is in its infancy.¹³

If our experience is any guide, it seems that people with dual disabilities require many attempts before a long-term community placement is possible. They may make five steps up the stairway to independent living and then fall back two or three. Each time they do this, they end up higher on the stairway until they have achieved some level of community living and acceptance. Encouraging and enhancing the "stairway" to community living will undoubtedly take new and novel medical and social

approaches to these problems. In the meantime, patience and realistic goals are the sine qua non of a successful approach for the individual with a dual disorder, as well as any other patient who does not seem to fit into current programs.

Given the length of stay and the high number of readmissions to the facility, cost becomes a critical issue. The board and lodging per diem at FSH is \$45.56, 80% of the statewide average of \$56.55. Compared with the cost of a state or other hospital, this is a real bargain.

But while FSH would seem to offer a humane, cost-effective method of treating and housing the severely mentally ill, changes in the regulatory environment may effectively disqualify the residents from critical federal funding. To achieve its objective of dispersing large, single-roofed facilities, the federal Health Care Financing Administration has used the so-called IMD (Institutions for Mental Diseases)

Table

Final discharges by type with average length of stay

Discharge type	Final discharges	Average length of stay
Community living	96	146 days
Detox	3	17
Hospital PVT CD	1	80
Hospital PVT MI	48	138
Hospital organic	2	137
Prison/jail	4	55
Regional treatment center	7	135
Other Rule 36	14	112
Total	175	136

rule to deny Medical Assistance benefits to residents of any institution with more than 17 beds. All residents of FSH are currently defined as residents of an IMD, even though the vast majority of residents live in units that have five or fewer beds. It is a confounding irony that FSH residents who are currently moving toward independence are denied access to basic medical services. The federal government's position has profound practical and clinical consequences, leaving large populations of severely and persistently mentally ill people with nowhere to turn because of the high costs of similar facilities.

CONCLUSION

In an overall clinical context, there is nothing conspicuous about FSH's approach to mental illness. There is a familiar chronicity to the struggles our residents experience, but the cluster and normal family living concepts enable many residents to deal with their illnesses and move on to community living in spite of serious disabilities.

MM

James Janeczek is president/treasurer of Familystyle of St. Paul, Inc.

REFERENCES

1. Adler A. The science of living (1929). New York, NY: Anchor Books, 1969.
2. Mosak HH, ed. Alfred Adler: his influence on psychology today. Park Ridge, New Jersey: Noyes Press, 1973.
3. Dreikurs R. Children: the challenge. New York, NY: Hawthorne Books, 1964.
4. Dreikurs R. Group psychotherapy and group approaches—collected papers. Chicago: Alfred Adler Institute, 1960.
5. Soltz V. Study group leaders manual. Chicago: Alfred Adler Institute, 1967.
6. Safer D. Substance abuse by young adult chronic patients: young adult chronic patients abuse of substances may lead to increased hospitalizations. *Hosp Community Psychiatry* 1987;38:551-4.
7. Lehman AF, Myers CP, Cotty E. Assessments and classification of patients with psychiatric and substance abuse syndromes. *Hosp Community Psychiatry* 1989;40:1019-25.
8. Policy Research Associates, Inc. Survey of Minnesota's Rule 14 and Rule 36 Programs. St. Paul, Minnesota: Minnesota Department of Human Services, 1990.
9. American Psychiatric Association. Diagnostic and statistical manual of mental health disorders: DSM-III-R. 3rd ed, rev. Washington, D.C.: American Psychiatric Association, 1987.
10. American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-IV. 4th ed. Washington, D.C.: American Psychiatric Association, 1994.
11. Versey B. Guidelines for the client characteristics and needs survey. New York, NY: State office of mental health bureau of survey and evaluation research, January 1989.
12. Kivlahan DR, Heiman JR, Wright RC, Mundt JW, Shupe JA. Treatment cost and rehospitalization rate in schizophrenic outpatients with a history of substance abuse. *Hosp Community Psychiatry* 1991;42:609-14.
13. Ridgley MS, Osher FC, Talbott JA. Chronically mentally ill individuals with substance abuse problems: treatment and training issues. Baltimore, Maryland: Baltimore Mental Policies Center, University of Maryland, 1997.

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Laws Prohibiting Physician Self-Referrals

The Impact on Health Care Integration in Minnesota

Physicians planning integration with other providers must scrutinize the still-ambiguous Stark prohibitions.

Margo S. Struthers, J.D., and Patricia J. Smith, J.D.

The expansion of the federal prohibition against physician self-referrals, known as "Stark II," which became effective January 1, 1992, has the potential to create many obstacles to health care integration efforts in Minnesota. The state's health care marketplace has encouraged many forms of integration, including physician-controlled integrated networks, health care cooperatives, hospital-sponsored networks, payer-initiated joint ventures, and hospital or payer acquisitions of medical practices. The various forms of integration commonly involve investment interests and compensation arrangements that may potentially violate the Stark II prohibitions if one of the many ambiguous exceptions does not apply to the arrangement.

Stark II was enacted in 1993 to expand the scope of federal law (Stark I) prohibiting physicians from referring patients to clinical laboratories in which the physicians (or their immediate family members) have a financial interest. The scope of Stark II is broad and its definitions are sufficiently ambiguous to concern physicians interested in pursuing health care integration opportunities.

A primary concern raised by both Stark I and Stark II is the lack of regulatory guidance. Proposed regulations relating to the enforcement of Stark I were published in March 1992 and were just released in final form in August 1995. To date, specific guidance with respect to the enforcement of Stark II has not been released.

However, the preamble to the final Stark I regulations states that the majority of the interpretations will apply to Stark II. Therefore, health care providers and their advisers are left to anticipate exactly how the Stark I regulations might apply to Stark II prohibitions.

Creating even more confusion, as *Minnesota Medicine* goes to press, Congress is considering the proposed Omnibus Budget Reconciliation Act of 1995 (OBRA '95), including the issue of how to respond to President Clinton's veto of the act. As it now provides, this bill would scale back substantially the scope of Stark II, delay its effective date until final regulations have been promulgated by the secretary of Health and Human Services, and make other substantive and technical changes. At the same time, OBRA '95 would expand in various ways federal enforcement of the fraud and abuse laws, in general. In addition, until Congress determines the breadth of Stark II, HCFA has apparently ceased working on the medical group practices attestation form, which was to have been submitted by group practices wishing to qualify for any exception as a group practice within 120 days of publication of the Stark I final rule.*

*A final technical amendment to the Stark I regulations was issued on December 11, 1995, providing that a group practice must submit an attestation for its carrier within 60 days after receipt of attestation instructions from its carrier.

These issues remain as part of the wider budget bill debate. Nevertheless, the law remains in effect until further legislation is enacted and must be considered by physicians analyzing integration opportunities.

OVERVIEW OF STARK I AND STARK II

PROHIBITIONS

Stark I was enacted in 1989 and became effective on January 1, 1992. It prohibits a physician from referring Medicare patients to any entity providing clinical laboratory services with which the physician (or an immediate family member) has a financial relationship. Stark II expands this prohibition to ban physicians from referring Medicare or Medicaid patients for certain "designated health services," including clinical laboratory services. Current law also prohibits making a claim for payment under the Medicare or Medicaid program for services provided based on a prohibited referral.

DESIGNATED HEALTH SERVICES

The designated health services to which Stark II currently applies are 1) clinical laboratory services; 2) physical therapy services; 3) occupational therapy services; 4) radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; 5) radiation therapy services and supplies; 6) parenteral and enteral nutrients, equipment, and

supplies; 7) prosthetics, orthotics, and prosthetic devices and supplies; 8) home health services; 9) outpatient prescription drugs; and 10) inpatient and outpatient hospital services. Under OBRA '95 as proposed, the list would be narrowed to 1) clinical laboratory services; 2) outpatient physical therapy and occupational therapy services; 3) radiology services, including magnetic resonance imaging, computerized tomography, and ultrasound services; and 4) parenteral and enteral nutrients, equipment, and supplies.

FINANCIAL RELATIONSHIP

For purposes of Stark II, a "financial relationship" includes an ownership or investment interest or a compensation arrangement. An "ownership or investment interest" is defined as an arrangement structured through equity, debt, or other means, and includes an indirect interest (an interest in an entity that holds an ownership or investment in any entity providing designated health services). A "compensation arrangement" is defined as any arrangement that involves remuneration between a physician (or an immediate family member) and an entity. OBRA '95, as proposed, would remove compensation arrangements from the definition of a financial relationship.

EXCEPTIONS

There are a few limited exceptions to the application of Stark II. These exceptions fall into three categories. Each exception has its own requirements; however, they are not described at length in this article. As proposed, OBRA '95 would make a number of changes to these exceptions.

General exceptions related to both ownership interests and compensation arrangements are as follows:

- physician services provided personally by the referring physician or under the personal supervision of another physician in the same group practice;
- in-office ancillary services; and
- certain federally qualified prepaid health plans.

The second category of exceptions, those solely related to ownership interests, are not likely to pro-

tect the development of most health care integration initiatives. These exceptions are as follows:

- ownership in publicly traded securities and mutual funds;
- ownership in hospitals in Puerto Rico;
- physician ownership of hospitals; and
- ownership in an entity providing designated health services in a rural area, if substantially all of the designated health services are furnished to individuals residing in a rural area.

The final category is exceptions solely related to compensation arrangements. They are as follows:

- bona fide employment relationships;
- personal services arrangements;
- physician recruitment by a hospital;
- lease of space or equipment;
- isolated transactions;
- payment by physicians for services and items;
- certain group practice arrangements with hospitals (the group practice exception must meet six requirements relating, in general, to services provided, billing, distribution of overhead expenses, basis of compensation, and amount of service provided by the members of the group); and
- hospital-paid remuneration that is not related to the provision of designated health services.

PENALTY

Violators of Stark II are subject to a mandatory refund of amounts billed in violation of the statute; possible civil monetary penalties of up to \$15,000 per violation; potential exclusion from Medicare, Medicaid, and other government reimbursement programs; and additional civil money penalties for circumvention schemes.

IMPACT OF STARK II ON HEALTH CARE INTEGRATION

FINANCIAL INTEREST

In light of the passage of Stark II into law, any relationship involving physicians that integrates formerly separate components of the health care

system must be reviewed to determine whether it creates a financial interest under Stark II. A determination that a financial interest exists could significantly curtail the activities of the integrating parties. The integration—cooperative, physician network, or other joint venture—should be implemented only after the parties analyze the future business activities of the new entity and the effect of Stark II on such activities. For example, if the new "integrated" entity will acquire a provider of a designated health service, any physician holding an ownership interest in the new entity may have an indirect financial interest in the provider and, thus, may be prohibited from making referrals.

The provision in Stark II that says debt creates a financial interest may lead to unexpected results in such an analysis. There is no exception from the financial interest based upon the amount of the debt, even if it's negligible; therefore, strict enforcement of this provision could result in a finding of financial interest even where there is a nominal amount of debt between a physician and a provider of a designated health service.

UNEXPECTED COMPENSATION ARRANGEMENT

When there is co-ownership in a third entity, some believe that a compensation arrangement between the venturing parties will be created as a result of the organizational financing of the third entity. For example, if a hospital pays for the organizational costs of a physician-hospital organization (PHO), there may be a direct benefit from the hospital to the physicians participating in the PHO. In such a scenario, the physicians could not refer patients to the hospital (for inpatient or outpatient services) without violating Stark II, unless some other exception applies.

BREADTH OF INPATIENT AND OUTPATIENT HOSPITAL SERVICES

A looming question is how the designated health service for inpatient and outpatient hospital services will be interpreted and whether this definition will correspond to the various

classifications used for Medicare reimbursement purposes. Currently, the definition of "inpatient hospital services" under general Medicare definitions excludes medical or surgical services provided by a physician. Whether the Stark II definition will also be so limited remains to be seen.

AMBIGUITIES IN THE GROUP PRACTICE EXCEPTION

The group practice exception is important to the application of Stark II. However, many ambiguities were not clarified in the recently released Stark I regulations. Generally, a group practice consists of two or more physicians legally organized as a professional corporation, partnership, or other similar entity in which the physicians deliver substantially all of their health services through shared office space, facilities, equipment, and personnel. One question is whether the "group" may have nonphysician owners or directors and still qualify as a group practice. Also, while group practices are allowed to compensate physicians with profit and productivity bonuses, it is unclear what is an acceptable means of determining personal productivity related to services provided by the physician. The Stark I regulations did clarify that employed physicians (including part-time) and contract physicians may be included as members of a group practice. The group practice exception must be carefully analyzed when creating integrated physician networks to ensure that the physicians are able to refer patients for other services through the network.

LIMITATIONS OF PREPAID SERVICES EXCEPTION

The "managed care exception" is not as broad as it seems. The managed care exception applies to federally qualified health maintenance organizations and certain Medicare prepaid contracts. There is no separate exemption for Medicaid managed care contracting for a non-federally qualified HMO. A number of ambiguities remain under this exception. Therefore, if an integrated group enters into managed care contracts for Medicare or Medicaid popula-

tions, the group must consider the application of Stark II to ensure that physicians within the group are able to refer patients for other services within the network.

IMPACT ON CERTAIN MANAGED CARE ARRANGEMENTS

Stark II attempts to address the compensation arrangement that induces a physician to reduce or limit

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medically necessary services. In a capitation arrangement or other risk-sharing approach to managing the health care provided to a population, it is generally understood that physicians may be induced to reduce the amount of services provided. Generally, the goal of Stark II is to reduce medically *unnecessary* services provided to Medicare and Medicaid recipients. To help assure that medically *necessary* services are provided, Stark II prohibits specific payments to a physician as an inducement to limit or reduce medically necessary services. However, until guidance is released on Stark II, it will be difficult to evaluate whether a managed care compensation arrangement induces a physician to limit medically necessary services or only unnecessary services.

The Group Health Association of America (GHAA) argued before the House Ways and Means Health Subcommittee that Stark II interferes with "the integration of physician practices with other health care pro-

viders." Common managed care compensation techniques that GHAA argues are "potentially subject to prosecution" include incentives such as lower copayments for use of a network physician, bonuses to physicians for meeting immunization goals, and vouchers to Medicaid enrollees who keep prenatal care appointments.

INTENT ELEMENT

Finally, there has been much speculation regarding the recent decision in *Hanlester Network v. Shalala*, which held that a "knowing and willful" violation of the federal Anti-Kickback Statute requires the defendants to specifically intend to disobey the law. Since intent is not a necessary element to violate Stark I or II, it may be attractive to the government to pursue possible Stark violations against providers rather than attempting to show specific intent to violate the Anti-Kickback Statute. While Stark is not a criminal statute, the potential for having sub-

stantial fines levied against a provider, as well as possible exclusion from the Medicare and Medicaid programs, is a major deterrent.

CORPORATE COMPLIANCE PROGRAMS

The development of a corporate compliance program, a set of written procedures and systems intended to detect and prevent violations of criminal and civil laws, could potentially assist health care providers, payers, and integrated systems monitor the financial relationships that may be affected by Stark I and Stark II and implement regulatory guidance. A corporate compliance program also can demonstrate intent to comply with Stark I and Stark II. In addition, such a program may benefit substantially those confronted with criminal prosecution under the Anti-Kickback Statute.

CONCLUSION

The consideration by Congress of various changes to Stark II and various federal laws addressing fraud and abuse, as well as the recent release of the Stark I regulations, reinforces the need for health care providers to continue to be alert to potential problems related to referrals arising from integration activities. The risk of substantial financial penalties and Medicare and Medicaid exclusion is too costly to ignore in this constantly evolving area of government enforcement. MM

Margo Struthers is a partner with Oppenheimer Wolff & Donnelly. At the time she wrote this article, Patricia Smith was an attorney with Oppenheimer Wolff & Donnelly in Minneapolis. Currently, she is tax-transactional counsel with General Mills, Inc., in Minneapolis.

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ANNOUNCEMENTS

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MMA AND MMGMA WILL PRESENT LEADERSHIP SEMINAR

The Minnesota Medical Association and the Minnesota Medical Group Management Association are co-sponsoring a half-day seminar, "Building Leadership for Change," on Wednesday, February 28, at the Hyatt Regency Hotel in Minneapolis. The speaker, Jack Silversin, D.M.D., Dr.Ph., will help health care leaders enhance their organizations' ability to compete in changing markets. The program will look at some of the fundamental shifts taking place in medical care delivery and discuss what it will take for physicians to master these changes and continue to be professionally satisfied. Topics include:

- new roles for physicians in health care delivery;
- new opportunities;
- coping with change.

The registration fee is \$50. For more information, call Karen Tourdot at the MMA, 612/378-1875 or 800/999-1875.

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MMA SPONSORS MEDICAL TERMINOLOGY SEMINAR

The MMA and the Profile Group will present a Basic Medical Terminology Seminar for coding and billing personnel on Thursday, January 11, at the Sheraton Inn Midway in St. Paul. The all-day seminar will cover the origin of medical terminology, prefixes, suffixes, combining forms, word roots, and step-by-step instruction on how to build and break down medical terminology. The registration fee is \$175 for the first registrant and \$150 for each subsequent registrant from the same group or clinic. For more information, call Vicki Westling or Karen Tourdot at the MMA, 612/378-1875 or 800/999-1875.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Wins Major Victories at AMA Interim Meeting

The Minnesota delegation to the American Medical Association won support for its resolutions on media violence and on postpartum stays during the AMA Interim Meeting December 3 to 6 in Washington, D.C. The AMA House of Delegates voted to promote the Minnesota Medical Association's campaign against media violence throughout the nation and voted to oppose insurance plan constraints on postpartum hospital stays for mothers and their newborns.

MMA Media Violence Campaign Goes National

In adopting the Minnesota delegation's media violence resolution, the AMA voted to expand its ongoing campaign against violence to include media violence and to promote campaigns like the MMA media violence campaign throughout the nation.

"The MMA is proud to take the lead in bringing the dangers of media violence to national attention," said Michael J. Murray, M.D., president of the MMA. "We are not asking for censorship, but we do intend to educate the public."

In June, the MMA launched a campaign warning that media violence is hazardous to children's health. Physicians began telling young patients and their parents that violent television, movies, and video games promote aggressive behavior and encourage children to see violence as an effective way to resolve conflicts. In addition, time spent in front of a TV, movie, or video screen is time spent *not* exercising. Chil-

dren sit passively watching programs that glamorize alcohol, cigarettes, drugs, and sex. They also see countless advertisements for unhealthy foods.

As part of its public information campaign, the MMA distributed the brochure, "Ten Tips for Parents to Stop the Media Violence," and a resource guide for physicians, produced a public service announcement for television and radio, and featured articles about media violence in the June issue of *Minnesota Medicine*.

AMA Supports MMA's Postpartum Stay Position

In addition to adopting the Minnesota media violence resolution, the AMA House of Delegates adopted a substitute resolution on postpartum stays for women and their newborns, which was based on a Minnesota resolution.

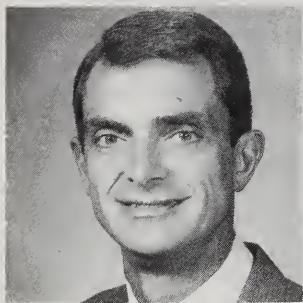
The AMA resolved to take the following action:

- oppose the imposition by third-party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the mother and the newborn;

- urge that payers provide payment for appropriate follow-up care for the mother and newborn;

- reaffirm AMA policy stating that economic considerations should not conflict with a physician's primary responsibility to serve his/her patient's best interest, that physi-

Victories continued on page 35



Viewpoint

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Michael J. Murray, M.D.
President, Minnesota Medical Association

MMA Speaks Out on National and State Issues

Advocacy on behalf of our patients and our profession is the main role of the Minnesota Medical Association. Opportunities for advocacy abound at both the national and state level.

As the Medicare debate in Washington continues, we support the American Medical Association's position on tort reform, antitrust relief, relief from Stark I and II and from the more onerous CLIA (Clinical Laboratory Improvement Act) regulations. We also favor increased patient choice.

In addition, the MMA is concerned about the geographic inequity in Medicare reimbursement rates. The adjusted average per capita cost (AAPCC) used for calculating reimbursement rates for Medicare recipients who join an HMO is only \$270 per month in parts of rural Minnesota. In Dade County, Florida, it is closer to \$670 per month. Obviously, one can design a much better HMO program for residents of Dade County than for citizens of Minnesota. This inequity exists despite the fact that all Medicare recipients pay the same number of dollars into the Medicare fund. The MMA has met several times with our Minnesota congressional delegation, and we continue to work through the Geographic Coalition, which was co-founded by the Minnesota Medical Association and the Utah Medical

Association to lobby for fair Medicare reimbursement rates in every state.

The proposed changes in Medicaid funding are another major MMA concern. Recent news reports indicate that Sen. Paul Wellstone and Gov. Arne Carlson actually agree on something—Minnesota should not be adversely affected by its past efficiency in delivering health care. Both Wellstone and Carlson have protested excessive cuts in federal funding for Minnesota's Medicaid program. Although Minnesota's Medicaid budget is currently growing by 10 percent a year, under the original block grant proposal it would be allowed to grow by only 2 percent a year.

The MMA has convened a task force to address Medicaid issues. We also have met with the commissioner of health and the assistant commissioner of the Department of Human Services to discuss ways to cope with the loss of federal funds. The DHS recognizes that eligibility and benefit levels must be re-evaluated. Currently, 30 percent of the recipients (disabled and long-term nursing home patients) consume 70 percent of the Medicaid budget. The DHS recommends that educational programs be developed to inform the disabled that they do not need to go on welfare to obtain health care. Something also must be done about senior citizens switching from Medicare to Medic-

aid in order to obtain the richer Medicaid benefits package. We will continue to work with DHS to address these issues.

When the Minnesota Legislature reconvenes on January 16, we will have many opportunities to speak on behalf of our patients and our profession. The MMA will try to pass a number of public health initiatives. Foremost among them is a proposal to require firearms to have a locking device, such as a trigger lock, cylinder lock, or barrel lock if children under age 18 are present or live in the house. We will also support helmet laws, anti-smoking legislation, and a continuing ban on fireworks.

For the first time in several years, we don't expect to see a major MinnesotaCare bill. Last session, we were successful in gaining the repeal of RAPO, improving the Data Practices Act, and making sure that all the money from the Health Care Access Fund will be used for the MinnesotaCare program rather than being absorbed into the General Fund. This year, we will continue to strive for a broad-based funding source for the MinnesotaCare program and will try to make sure the safety net for the uninsured remains intact. With the changes brewing in Washington, this may be a tall order.

We will pursue a number of other legislative initiatives as well. The Minnesota Board of Medical Practice has drafted legislation that we fear could further decrease physicians' due process and confidentiality rights. After a recent meeting with BMP leaders, however, I am optimistic that we can reach an acceptable compromise.

We will also continue to pursue the MMA professional liability reform legislation that was introduced last session but failed to receive a hearing.

These are some of the most important MMA issues for 1996. Whenever decisions are being made that affect the welfare of our patients or our profession, we will be at the table.

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Victories continued from page 33

cians should protest when they are urged by a payer to discharge a patient when such discharge is against the physician's clinical judgment, and that physicians should so inform the patient; and

- develop model state legislation that would include provisions eliminating the ability of third-party payers to impose mandatory constraints on hospital stays for vaginal deliveries and cesarean sections.

The substitute AMA resolution accomplishes the intent of the original Minnesota resolution, which called on the AMA to oppose the imposition by third-party payers of one-day stays for vaginal deliveries and three-day stays for cesarean sections. It also asked the AMA to urge that insurance coverage provide for one or more home visits by a nurse to the mother and newborn after hospital discharge. (See page 39 for information on the MMA's efforts on the state level to preserve appropriate care for mothers and their newborns.)

AMA Supports Geographic Equity

The AMA reaffirmed and expanded its policy on geographic equity in capitation rates, which originated in response to a 1994 Minnesota resolution. Before the revision, AMA policy stated that geographic variations in capitation rates in public programs such as Medicare and Medicaid should reflect only "demonstrable variations in practice costs and utilization."

The AMA House of Delegates expanded this policy to specify that "demonstrable variations in practice costs" should reflect such costs as hourly staff wages and rent per square foot and to specify that valid variations in utilization should reflect "demonstrable differences in health care need." The revised policy also states that areas with utilization rates that are relatively low because of cost containment efforts should not be penalized with unrealistically low reimbursement rates. Payments should be adjusted at the individual

level with improved risk adjusters that include demographic factors, health status, and other useful and cost-effective predictors of health care use.

This revised AMA policy on geographic equity should also apply to any geographic adjustments in the proposed MedicarePlus program. The AMA modified its policy supporting a national Medicare contribution that would allow beneficiaries to buy private insurance. Its new policy states that the Medicare contribution should equal the national average risk-adjusted actuarial value of covering individuals with traditional Medicare coverage, adjusted geographically in accordance with the new AMA policy on geographic equity.

The AMA House of Delegates also voted to support small-scale demonstrations of alternative methods of varying geographically fixed payments by public programs before they are implemented, and to provide information to physicians that would help them develop and maintain equitable compensation arrangements under capitated and uncapped systems.

AMA Opposes Ambulatory Patient Groups

Responding to a Minnesota resolution adopted at the 1995 AMA Annual Meeting in June, the AMA filed a report and adopted policy on ambulatory patient groups (APGs). The Minnesota delegation had requested this study after the Health Care Financing Administration recommended to Congress that Medicare begin phasing in APGs for payment of hospital outpatient surgical, diagnostic, and radiology services. Under APGs, a bundled payment covers all facility, technical, and supply costs for an outpatient visit. This replaces a facility payment to the hospital in addition to the provider payment.

After reviewing the background and status of APGs, the AMA House of Delegates voted to oppose lump-sum prospective pricing systems to hospitals for outpatient services that are based on a bundling approach.

The AMA will continue to monitor and advise the Department of Health and Human Services and Congress on their efforts to implement a prospective pricing system for Medicare outpatient services.



Testifying before Reference Committee B, Thomas A. Stolee, M.D., called APGs a "major threat to physicians everywhere." After serving nine years on the Minnesota AMA delegation, Stolee attended his last AMA meeting as a delegate. He was active on many issues, including postpartum coverage, geographic equity in capitation rates, and the reorganization of the Federation.

AMA to Reconsider Anencephalic Neonate Stand

The AMA House of Delegates called on the AMA Council on Ethical and Judicial Affairs to reconsider its position favoring the use of anencephalic neonates as organ donors under certain circumstances. The MMA House of Delegates took a position opposing the AMA stand at the 1995 MMA Annual Meeting in September.

Interpreter/Translator Report Needs Work

Responding to a Minnesota resolution adopted at the 1995 AMA Meeting in June, the AMA Board of Trustees presented a report on interpreter/translator services and recommended that the AMA monitor enforcement of relevant law. The report and

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ANNOUNCEMENTS

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MINNESOTA PHYSICIANS ARE PROMINENT AT THE AMA INTERIM MEETING

Richard B. Tompkins, M.D., chaired the Minnesota delegation to the AMA House of Delegates. Other delegates included Robert D. Christensen, M.D., E. Duane Engstrom, M.D., A. Stuart Hanson, M.D., Thomas A. Stolee, M.D., Audrey M. Nelson, M.D., Ben P. Owens, M.D. The alternate delegates included Frank J. Indihar, M.D., Theodore L. Fritsche, M.D., Thomas L. Peyla, M.D., C. Randall Nelms, M.D., Carolyn J. McKay, M.D., Bruce A. Norbeck, M.D., and Lyle Munneke, M.D.

McKay served on Reference Committee D, which dealt with public health issues. Jasper M. Daube, M.D., representing the American Association of Electrodiagnostic Medicine, served on Reference Committee A, which dealt with Medicare and health system reform. (Daube is the MMA representative on the Minnesota Health Care Commission.) William E. Jacott, M.D., is serving his third term on the AMA Board of Trustees. Past MMA presidents Thomas A. Stolee, M.D., and C. Randall Nelms, M.D., served at their last AMA meeting before leaving the Minnesota delegation. Nelms will represent his specialty society of otolaryngology at the AMA.

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JOIN AN MMA COMMITTEE

Serving on an MMA committee is an excellent way to keep up to date on interesting issues and to voice your concerns and opinions. To be considered for appointment, please call your component medical society, or call Jane Phillip at the MMA at 612/378-1875 or 800/999-1875. She can also give you more information about the activities of each committee and about the appointment process.

Victories continued from page 35

its recommendations were referred to the AMA Board of Trustees for further study.

The Minnesota delegation had called on the AMA to 1) study the legal requirements, both federal and state, for provision of qualified medical interpreters/translators; 2) work with appropriate government agencies to develop a definition for "qualified medical interpreter;" 3) if appropriate, develop model legislation to clarify the responsibilities of physicians to make interpreter services available, including the establishment of a payment mechanism separate from reimbursement for office visits; and 4) provide a report to the House of Delegates at the 1995 Interim Meeting.

The AMA Board of Trustees' report to the House of Delegates recommended that the AMA monitor enforcement of those provisions of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990 that require recipients of federal funding at public accommodations, including physicians' offices, to provide qualified interpreters/translators, and that the AMA ascertain if clarification of physician responsibilities is needed. Physicians testifying before Reference Committee B, however, expressed concern that enforcement is too unpredictable and that it is philosophically objectionable to some physicians. The reference committee concluded that more information is needed to address the question of payment for interpreter or translator services and the establishment of model state protocols. The committee also recommended that the Board further explore the legal issues involved and the possibility of working with advocacy groups for the hearing impaired to arrive at solutions. The AMA House of Delegates adopted the reference committee's recommendation to refer the report and its recommendations back to the Board and to request a report at the 1996 AMA Annual Meeting in June.

AMA Will Consider Ways to Encourage Self-Insureds to Pay for Immunization

The MMA resolved at its 1995 Annual Meeting to call on the AMA to seek federal legislation that would require self-insured plans to cover immunizations. At the AMA Interim Meeting, the AMA adopted policy that addresses possible state solutions to this problem.

The AMA considered a Board of Trustees Report on the possibility of seeking an amendment to the Employee Retirement Income Security Act (ERISA) that would require self-insured employee benefits plans to comply with state laws mandating coverage for immunization. The AMA House of Delegates adopted, as amended, the two recommendations in the report.

In adopting these recommendations, the AMA resolved to continue to "educate physicians and patients on private sector educational strategies related to immunization coverage." The report stressed the importance of educating health plans and the public about the cost-effectiveness of immunizations and other preventive health measures.

The AMA also resolved to continue to advise physicians on opportunities to design new state laws to advance broad-based health system reform initiatives, consistent with new case law established by the U.S. Supreme Court in the *Travelers* case, and to investigate ways to use the state tax laws to impose accountability on ERISA-regulated managed care plans and, where appropriate, to draft model legislative provisions to assist the Federation on these issues.

The AMA had previously considered the pros and cons of encouraging states to propose tax inducements for self-insured plans to comply with state immunization laws, but ERISA was thought to be an insurmountable barrier. The playing field changed in April 1995, however, when the Supreme Court ruled that a New York state surcharge on hospital bills submitted by patients insured by employer-sponsored

health plans does not violate ERISA as the Travelers Insurance Company had charged. The court found that ERISA was not intended to preempt state health reform initiatives such as taxes, if the taxes had only an "indirect economic influence." The court decision noted, however, that state laws requiring self-insured plans to cover certain benefits would be considered violations of ERISA because they would be direct attempts to regulate the plan's operation. A later court ruling clarified that state taxes are permissible under ERISA as long as they do not cause a direct, material economic effect, such as forcing plans to change their method of operation. The Travelers decision suggests that broad state regulation affecting both insured and self-insured plans will be more likely to withstand an ERISA challenge.

AMA Considers Ways to Restructure Federation

The Federation of Medicine must be restructured if it is to speak credibly on behalf of the entire profession and be an effective force in the 21st century, the AMA concluded at the AMA Interim Meeting. A consortium of the Federation, representing more than 200 county societies, state societies, specialty societies, and the AMA has been working for the past

two years to develop recommendations on how to reshape the Federation. Thomas A. Stolee, M.D., represented the MMA on the consortium; Roger Johnson represented Ramsey Medical Society; and Audrey M. Nelson, M.D., represented large group practices. The Project Team of the Study of the Federation developed a report based on the consortium's findings, which recommended 35 specific changes, including greater specialty society representation in the AMA House of Delegates and an increase in the size of the AMA Board of Trustees. The goal is to reshape the Federation of Medicine so that it truly reflects the needs and opinions of its diverse membership.

The special reference committee, assigned to consider the report, heard testimony supporting the need to represent all aspects of a physician's life, such as mode of practice and ethnic and cultural identity. There was also agreement that certain segments of the physician population, such as international medical graduates (IMGs), women physicians, and minority physicians need organizational structures that respond to their particular needs. But there was conflicting testimony on the specific recommendations to change AMA representation. As a result, the AMA

House of Delegates decided to call for further study and put off specific and controversial decisions until the 1996 AMA Annual Meeting.

Some decisions, however, were made. The federation's basic form will continue. The AMA will remain the umbrella over state, county, and specialty societies, but additional components may be added. Specialty societies will now get a bonus delegate for being unified as the state societies do.

The AMA asked the Project Team of the Study of the Federation to further consider a number of questions, including:

- how to determine the number of specialty society delegates;
- how to expand AMA representation to reflect mode of practice and demographic, ethnic, and cultural factors; and
- how to conduct a smooth transition.

A report is due to the 1996 AMA House of Delegates.

The Council on Long-Range Planning is investigating alternative organizational structures for IMGs, women, and minority physicians.

A special committee of the AMA House of Delegates will study the need to expand the size of the AMA Board of Trustees and make its elections more user friendly. • • • • •

Members Respond to 1995 MMA Annual Report

• • • • • THIS YEAR, FOR THE FIRST time, the Minnesota Medical Association sent all members an annual report describing MMA activities. A survey/response card on the back cover encouraged members to let MMA leaders know how well their association was meeting their needs.

The survey asks members to identify which MMA services they use and to evaluate the effectiveness of the MMA's legislative, pol-

icy and communications efforts during the past year. It also asks whether members believe their dues dollars are being properly allocated.

Data collected so far shows most members are pleased with MMA efforts.

• Seventy-five percent of members responding to the survey said they believe their dues are being allocated properly.

• Satisfaction scores for the various MMA departments were the

highest recorded since the MMA began tracking member satisfaction on a regular basis. The average overall satisfaction ranking with MMA efforts was 2.98 on a four point scale. The previous best ranking was 2.78.

• The annual report was ranked as a valuable service by 64.4 percent of respondents.

"Thanks to all of you who responded," said Michael Soucheray, marketing director. "If you have not yet had a chance to return your survey card, please feel free to do so. Your input is very important to your professional association."

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MEDICARE AND MEDICAID

VETOED BUDGET BILL HAD BEEN STRIPPED OF REFORMS

Before the Republican budget reconciliation bill was vetoed by President Clinton, it had been stripped of most of the provisions that led organized medicine to support the House version of the bill. Under heavy attack from trial lawyers, the medical liability reforms, including the \$250,000 cap on non-economic liability, were deleted by the House/Senate conference committee. The Senate stripped away the antitrust language in the conference report that would have allowed provider-sponsored networks (PSNs) to serve Medicare patients, as well as the CLIA physician office lab exemption. Both provisions fell victim to the Senate's Byrd rule, a parliamentary point of order that allows senators to exclude from the budget bill any provisions that have no direct dollar impact.

The final GOP bill did include the medical savings account provision, but MSAs may fall in the next phase of negotiations since the White House and consumer groups oppose them. As the second round of debate begins, the AMA continues to press for antitrust provisions that will allow the creation of PSNs to serve Medicare patients, CLIA relief, medical liability reform, and MSAs. The GOP House leadership may introduce a technical corrections bill that would include the measures deleted under the Byrd rule.

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CLINTON AND CONFERENCE COMMITTEE ARE FAR APART ON MEDICAID

The Medicaid provisions of the GOP budget bill calling for block grants and no individual entitlement would result in seven-year savings of about \$163 billion. President Clinton's balanced budget plan would save \$54 billion in Medicaid growth through per-capita caps. A compro-

mise plan has been devised by Rep. Martin Sabo and other members of The Coalition, a group of mostly moderate and conservative House Democrats. The Coalition's proposal would cut projected Medicaid spending by \$85 billion over seven years through per-capita caps and other changes.

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FUTURE OF MEDICARE PAYMENT IS UNKNOWN

In the wake of President Clinton's veto of the Republican budget bill, HCFA is considering various possibilities regarding the 1996 Medicare fee schedule conversion factors.

If there is no quick agreement on a budget bill and the government is operating on continuing resolutions, HCFA will go forward with the Part B Medicare conversion factors it has set for 1996—\$40.80 for surgery, \$35.42 for primary care, and \$34.63 for other. (The conversion factor for primary care services dropped from \$36.38 because the number of services exceeded the volume performance target.)

If a new budget is signed into law soon after January 1, 1996, HCFA may hold Medicare claims and pay them later with interest. Currently, HCFA is contacting the Medicare carriers to determine whether they are able to mass adjust and to find out how quickly they can make changes. No final decisions have been made.

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1996 PAR AGREEMENTS

The 1996 Medicare participation agreements have been mailed out, but if Congress passes a bill setting a single conversion factor of \$35.42 as Republicans have proposed, Medicare payment could change after physicians have signed the agree-

ment. HCFA is considering allowing for a special enrollment period to allow physicians to change their minds about participating, but this is only a possibility. Minnesota physicians who choose to remain non-participating providers should remember that effective January 1, 1996, balance billing to Minnesota residents is no longer allowed.

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MEDICARE CARRIERS WILL CRACK DOWN ON CODING

Beginning January 1996, Medicare carriers began screening claims to automatically identify inappropriate CPT code combinations and determine payment. The screening is programmed to spot 87,000 incorrect coding combinations, including comprehensive and component code combinations and mutually exclusive coding combinations that represent services or procedures that would not or could not be performed at the same time based on the CPT code description or standard medical practice.

Copies of the "National Correct Coding Policy Manual for Part B Medicare Carriers" is available from the National Technical Information Service at 703/487-4650. The cost is \$189 for the manual, or \$90 for a diskette.

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DEADLINE FOR FILING GROUP PRACTICE ATTESTATION EXTENDED

The deadline has been extended for group practices to file a statement with their Medicare carriers indicating that the group practice meets requirements for the group practice exception. The original deadline to file an attestation was December 12. The new deadline is April 5, 60 days from December 11, the date a notice was published in the *Federal Register*.

MMA Gears Up for 1996 Legislative Session

The MMA has a long list of goals for the 1996 legislative session and a relatively short time to achieve them. This year's legislative session is the second half of the biennium, the so-called "short session," which begins January 16 and is expected to end before Easter.

Some important proposals the MMA supported last year, such as the cigarette tax increase and tort reform legislation, are still alive. The MMA will continue to work for a broad-based funding source for the MinnesotaCare program. Other bills supported by the MMA that failed last session, but could be revived in 1996, call for antitrust protection for small clinics, medical savings accounts, stricter seat belt laws, and a snowmobile helmet law.

Last session, the MMA successfully opposed bills that would have allowed chiropractors to perform truck drivers' physical examinations and that would have established a licensing board for physical therapists. These bills could be revived.

The MMA also plans to initiate new legislation.

Firearm Lock

The MMA has already drafted legislation to require locks, such as trigger locks, cylinder locks, or barrel locks, on firearms stored in homes where children under age 18 live or are present. Support is building for this proposal. The Gun Violence Action Team of the Ramsey County Initiative for Violence Free Families and Communities and the Minnesota Children's Defense fund have endorsed the MMA proposal. In addition, Attorney General Hubert Humphrey III has chosen the MMA draft bill to be the subject of a youth summit January 17 in St. Paul. High school students from across the state will come to the Capitol to testify on this legislation.

Postpartum Hospital Stays

Postpartum insurance coverage is

expected to be hotly debated at the Legislature this session. Janette Strathy, M.D., testified on behalf of the MMA at an interim legislative hearing on postpartum hospital stays on November 16 in St. Paul. Strathy told the House Health and Human Services Committee and the Insurance Subcommittee of Financial Institutions and Insurance that the MMA would support legislation that would allow patients up to 48-hour insurance coverage for a postpartum stay, but that legislation should not prevent a physician from recommending a 24-hour discharge with an appropriate follow-up home visit.

The MMA has worked with Rep. Joe Opatz, DFL-St. Cloud, on his draft proposal that would require health plans to provide coverage for at least 48 hours of inpatient care following a vaginal delivery and 96 hours following a cesarean section if this inpatient care was determined by the physician and patient to be medically necessary. If a shorter hospital stay was considered appropriate by the physician and patient, the health plan would be required to cover a home visit by a registered nurse. Insurance plans oppose this proposal, arguing that it could serve as an incentive for more companies to self-insure.

Restructuring State Programs

One of the most challenging issues that will face the 1996 Legislature—the probable loss of federal funds—cannot be fully addressed until the specifics of the federal budget reconciliation bill are decided. The state is braced, however, for a significant loss of federal dollars for the Medicaid program. The vetoed budget reconciliation bill would have provided \$1.9 billion fewer federal dollars for Minnesota over a seven-year period. The MMA is working with the Minnesota Department of Human Services to prepare for an expected loss.

A comprehensive MinnesotaCare bill is not expected this year, but legislators may have to make some decisions about the MinnesotaCare program. How will the DHS merge MinnesotaCare with the Medical Assistance and General Assistance Medical Care programs? Will the state decide to scrap ISN rules now that RAPO has been repealed? What will happen to the surplus that is expected to accrue in the Health Care Access Fund?

BMP Seeks Changes in Disciplinary Procedure

The Minnesota Board of Medical Practice currently plans to introduce legislation calling for changes in the BMP's disciplinary procedure. The BMP draft legislation is based in part on recommendations developed by the Consultation Group on Physician Sexual Misconduct.

The MMA has a number of concerns about the BMP draft legislation. The MMA opposes a BMP proposal to allow publication of notices of contested case hearings. Contested case hearings take place if a physician rejects the BMP disciplinary sanction recommended by a complaint review committee and requests a hearing before an administrative law judge. Currently, the notice of the hearing is confidential. The MMA opposes making the notice public because it would allow allegations that could destroy a physician's practice to be published before the hearing takes place. The MMA also opposes a proposal that would allow the BMP to share confidential data with criminal law enforcement agencies.

The MMA has testified about these and other concerns regarding the BMP draft bill at public forums in Mankato, the Twin Cities, Duluth, and before the BMP's Public Policy Committee, and has shared these concerns with the full board at its November meeting.

The MMA is working with the BMP in an effort to determine whether a compromise can be reached on these issues and to avoid a battle at the Legislature.

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MINNESOTA CARE

LAWMAKERS SEEK REPEAL OF MINNESOTA CARE PROGRAM

A group of state legislators, led by Sen. Linda Runbeck, R-Circle Pines, is calling for the repeal of MinnesotaCare legislation. Public meetings have been held in Rochester and Mankato at which Runbeck criticized MinnesotaCare for failing to decrease the number of uninsured and for driving physicians out of the state.

Supporters of MinnesotaCare point out that the program has cut more than \$26 million from Aid to Families with Dependent Children spending and has held Minnesota's uninsured population steady while the number of uninsured is rising throughout the nation. The Department of Human Services reports that in June AFDC's caseload was about 8,250 less than it would have been without the MinnesotaCare program. The drop in AFDC recipients saves \$2.2 million per month, or \$26.4 million annually.

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LOC CONSIDERS 1996 HEALTH SYSTEM AGENDA

The Legislative Oversight Commission on Health Care (LOC) met December 4 at the Capitol in St. Paul to prepare for the 1996 legislative session. The bipartisan commission, representing both the House and Senate, is chaired by Minneapolis DFLers Sen. Linda Berglin and Rep. Lee Greenfield.

Legislators noted that by 1999 there will be a \$357 million surplus in the Health Care Access Fund, which is funded in part by the 2 percent provider tax on health care services. The state proposes to merge the MinnesotaCare program with Medical Assistance and General Assistance Medical Care, eliminate the Health Care Access Fund, and put the money into the General Fund to pay for the consolidated pro-

grams. Greenfield said he would move to repeal the 2 percent provider tax before he would support its use for purposes other than the MinnesotaCare program.

Some LOC members, including Berglin, Sheila Kiscaden, R-Rochester, and Rep. Roger Cooper, DFL-Bird Island, expressed concern that the proposed move to managed care for the MinnesotaCare program may be proceeding too rapidly. They fear there may not be sufficient infrastructure to support managed care in some rural areas of the state.

The state will have to move rapidly if it is to propose MinnesotaCare legislation. According to Senate rules, state agency bills must be introduced at least two weeks before the first committee deadline, which is February 9. Bills must have passed out of all policy committees in either the House or Senate by the first deadline.

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MCHA SEEKS NEW FUNDING SOURCE

The Universal Coverage Committee of the Minnesota Health Care Commission is discussing ways to expand the funding base for the Minnesota Comprehensive Health Association (MCHA). Currently, MCHA is funded through enrollee premiums and by a tax assessment on health plans. The tax is not paid by self-insured companies, however, because federal ERISA law prevents states from taxing or regulating employee benefits. The Universal Coverage Committee is looking for ways to draw the self-insured plans into paying for MCHA. Sen. Linda Berglin, DFL-Minneapolis, is expected to propose an additional 2 percent tax on hospitals and HMOs. This would replace some existing taxes but would leave in place the 2 percent provider tax and the \$400 physician license surcharge. Berglin is

proposing the change because the provider tax can be passed on to self-insured companies. The Minneapolis Chamber of Commerce is proposing that the state rededicate 5 cents of the cigarette tax to the Health Care Access Fund. When the HealthRight Bill was enacted in 1992 it raised the cigarette tax by 5 cents to partially fund the MinnesotaCare program, but that money has since reverted to the General Fund.

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CHANGES IN GROWTH LIMITS ARE POSSIBLE

The Minnesota Department of Health may consider changes to the state's growth limits on health care spending. The MDH Cost Trends and Measurements Committee has recommended that the state set "cost-containment goals" rather than enforce the growth limits. This would leave the door open so the Legislature could revisit this issue if health care spending turns out to be higher than the state's target.

The Monitor

JANUARY 1996

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Medicare Reform: What's at Stake?

A presidential veto of Congress' proposed budget sets the stage for intense negotiating over Medicare reform. Here's a look at some behind-the-scenes concerns.

Janet Silversmith

When the Annual Report from the Social Security and Medicare Trust Funds Board of Trustees came out in April 1995, the news was grim. While the financial status of the Hospital Insurance Trust Fund improved somewhat in 1994, the board projected it would be exhausted in about seven years. The Supplementary Medical Insurance Trust Fund, although in balance annually, is growing at an unsustainable rate. In addition, this fund is primarily funded by general revenues, contributing to the nation's budget deficit. "The Medicare program is clearly unsustainable in its present form. It is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative,"¹ noted Stanford Ross and David Walker, the public trustees.

The Republican Congress has taken the trustees' warning seriously and is seeking to reduce Medicare outlays by \$270 billion over the next seven years. The congressional leaders view the change as a "reduction in the rate of growth" rather than as "cuts" to the program. The annual growth rate in the program currently hovers around 10 percent. In order to achieve the \$270 billion in reduced costs by the year 2002, the growth rate must be trimmed to about 5 percent or 6 percent annually.

At the end of November 1995, Congress passed a Medicare proposal as part of its omnibus budget reconciliation package, but President Clinton vetoed the bill on December 6. This article identifies some of the reasons for the apparent Medicare crisis and reviews the impact of some controversial issues—the Part B premium, the status of the traditional Medicare program, the challenges of the MedicarePlus program, and how the proposed changes might affect physicians.

MEDICARE: AN OVERVIEW

Despite the warning from the Medicare program trustees, there is considerable debate as to whether or not Medicare faces a crisis. Congressional Republicans have argued that swift and comprehensive action is necessary to preserve the program and to balance the federal budget. Democrats contend that the extent of the Medi-

care crisis is overblown, that steps to maintain the program's solvency have begun, and that Medicare should not be a tool for Republican tax policy. Clearly, the bulk of this debate is political. Regardless of personal opinions about when and how Medicare should be addressed, however, it appears that change of some sort is certain. Despite short-term political maneuvering, the long-range forecasts for Medicare solvency are bleak and deserve policy debate.

Congress passed the Medicare program in 1965 as Title XVIII of the Social Security Act. The program is administered by the Health Care Financing Administration (HCFA), part of the U.S. Department of Health and Human Services.

Medicare has two distinct components, Part A and Part B. Part A Medicare, or hospital insurance (HI), is an automatic entitlement for individuals over age 65 who are eligible for Social Security. Persons disabled for at least two years and persons with end-stage renal disease are also entitled to Medicare Part A benefits. Part A provides coverage for inpatient hospital services, skilled nursing facility services, and home health and hospice care services. Financing for Part A is accomplished through a payroll tax at a rate of 1.45% on employers and employees.

Medicare Part B, supplementary medical insurance (SMI), is a voluntary program. Eligibility is limited to individuals already on Part A or to those over age 65. Covered under Part B Medicare are physician services, other outpatient services, and medical equipment and supplies. Part B is a premium-based program; enrollees contribute a monthly premium (\$46.10 in 1995) and an annual deductible (\$100 in 1995) to the cost of the program. General revenues finance the rest.

MEDICARE: FACTS AND FIGURES

In 1993, approximately 36 million individuals were enrolled in Medicare (Parts A and B); 812 individuals consumed services per 1,000 enrollees.² In 1993, there were 616,480 Medicare enrollees in Minnesota, about 13.5 percent of the state's population; 769 individuals

per 1,000 enrollees actually used Medicare services. Approximately 91 percent of Minnesota enrollees were entitled because of age, another 8 percent because of a disability, and the remaining 1 percent were entitled as a result of end-stage renal disease.²

Like private health care coverage, Medicare costs have escalated as a result of numerous factors, including demographic changes in the general population and in the Medicare population, technological advances, and increased utilization of services. Figure 1 shows the distribution of the 1993 Medicare population by age. An aging population and greater longevity have resulted in significant program changes and increased costs. The Medicare population is not only aging, it is also becoming more disabled. Approximately 11 percent of all beneficiaries are disabled, and this figure is expected to rise to 17 percent by 2010.² Significantly, the over-65 population (12 percent of the total population) accounts

for 36 percent of the nation's health care expenditures.

Medicare is an entitlement program primarily based on age, not income. Figure 2 shows the distribution of Medicare beneficiaries by poverty status. As is true for the general population, the majority of Medicare beneficiaries have incomes below 300% of poverty. Notably, 83 percent of all Medicare expenditures are spent on beneficiaries with incomes at or below \$25,000; only 3 percent are spent on beneficiaries with incomes above \$50,000.³

The vast majority of 1993 Medicare expenditures are attributed to hospital inpatient services (53%) and physician* and supplier services (27%).² The distribution of expenditures, however, has been changing over the past several years as home health and outpatient-based services have expanded. The 1993 average Medicare payment (Parts A and B) per enrollee was \$3,616 (note that this differs from the average payment per person served, which was \$4,387 in 1993).² Medicare payments vary significantly across states. For example, Minnesota, which in 1993 represented 1.7 percent of the nation's Medicare enrollees, accounted for 1.2 percent of total program payments, or an average per-enrollee payment of \$2,567. In contrast, Louisiana had about 1.5 percent of all Medicare beneficiaries but accounted for 2 percent of all program payments, or \$4,526 per enrollee. The District of Columbia had the highest average payment per enrollee, \$4,973, in 1993. Hawaii had the lowest, \$2,183. Just six states accounted for 42 percent of all Medicare spending in 1993—California, New York, Florida, Pennsylvania, Texas, and Illinois.²

Medicare faces severe cost pressures. In 1970, Medicare payments totaled \$7.3 billion, and all personal health care expenditures† totaled \$64.8 billion, or 6.4 percent of the gross domestic product (GDP). By 1993, Medicare expenditures exceeded \$151 billion, and personal health care expenditures totaled

\$782.5 billion (of which Medicare accounted for 19.3 percent), or 12.3 percent of GDP.² Notwithstanding congressional interest, cost containment has been and is an important goal for the Medicare program.

PART B PREMIUM

When Medicare was originally established, the Part B premium was envi-

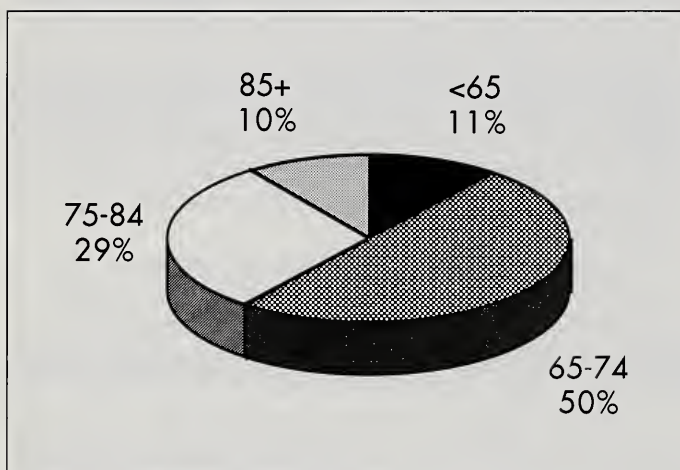


Figure 1—Age distribution of Medicare population, 1993.²

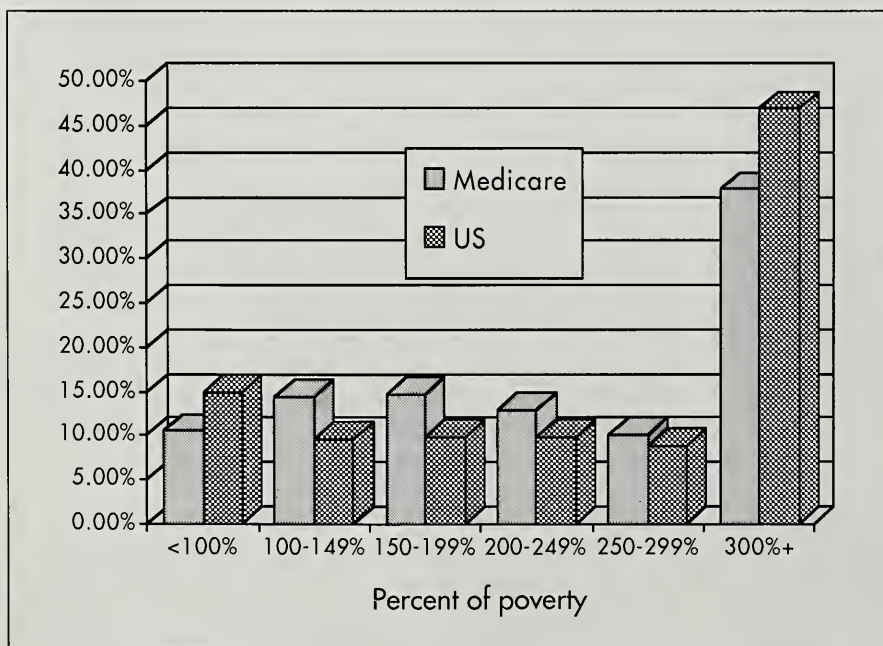


Figure 2—Distribution of U.S. and Medicare populations by poverty status.²

*The Medicare program defines a "physician" as a medical doctor (M.D. or D.O.), a chiropractor, or a podiatrist.

†Personal health care expenditures include all purchased services and products that are associated with individual health care, such as hospital, physician, dental services, nursing home care, drugs, and medical supplies; expenditures for construction, administration, public health activities, and research are excluded (HCFA, 1995).

sioned to cover one-half of Part B program costs. Congress changed this policy in 1974 and limited increases in Part B premiums to the same percentage increase applied to Social Security cash benefits through cost-of-living adjustments (COLAs). Increases in the COLA are intended to reflect general price inflation and are measured by the Consumer Price Index (CPI). Growth in the Medicare program exceeded general inflation and, consequently, Part B premiums quickly fell to under 25 percent of program costs. Effective January 1984, Congress changed the financing policy again and required that increases in the premium continue to reflect 25 percent of program costs and that the remaining 75 percent of costs be covered by general revenues. As part of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Congress again altered the policy and set in law the premium amounts for 1991 to 1995 based on estimated program costs; the statutorily set premiums were intended to reflect 25 percent of program costs. The cost estimates upon which premiums were set, however, were higher than actual costs; therefore, the 1995 premium of \$46.10 per month represents about 31.5 percent of program costs. As a result of OBRA '93, in which Congress returned to a policy that would set premium levels at 25 percent of program costs as defined by the secretary of Health and Human Services, the premium in 1996 (absent any law change) is anticipated to be lower than the 1995 premium.⁴

The recommendation contained in this year's budget reconciliation bill, however, would have frozen the Part B premium at the 1995 contribution level of 31.5 percent of program costs, which would result in a 1996 premium of about \$53.40. This change was expected to save the program about \$44 billion over seven years.⁴ The congressional proposal called for introducing a means-tested premium. It would have reduced the government's subsidy of the premium for individuals with incomes above \$75,000 and for couples with incomes above \$125,000; it would have eliminated the subsidy entirely at \$100,000 for individuals and \$150,000 for couples. President Clinton has indicated that he would support a premium set at 25 percent of program costs.

EXPANDED OPTIONS

MedicarePlus is the name of the newly created program contained in the congressional budget reconciliation bill that would have provided beneficiaries the option of enrolling in a variety of health care delivery models. Specifically, the proposal would have allowed beneficiaries who are eligible and who are enrolled in Parts A and B to choose coverage from the following: 1) a traditional Medicare fee-for-service plan; or 2) a MedicarePlus Plan defined as one of the following options:

- coordinated care plans, e.g., HMOs and PPOs;
- high-deductible plans (limited to \$6,000) combined with a medical savings account;
- provider-sponsored organization plans;
- union or association plans;
- fee-for-service plans that reimburse providers on the basis of a privately determined fee schedule; and

- any other types of plans.

Beneficiaries could choose any of the options that are available in the county or area in which they reside.

The Congressional Budget Office predicts that the MedicarePlus program would save the Medicare program about \$27 billion over seven years, assuming that 24 percent of all beneficiaries would enroll in a MedicarePlus plan by the year 2002.⁵

TRADITIONAL MEDICARE PROGRAM

The traditional Medicare fee-for-service program would remain an option, operating in much the same way as it currently does. Physician reimbursement would continue to be based on the Resource-Based Relative Value Scale (RBRVS), but the level of payment and the process for updating the fee schedule would change dramatically. Currently, three different conversion factors are applied to the relative value units of each service or procedure. Surgical services are based on a \$39.45 conversion factor; primary care services on \$36.38; and all other services on \$34.62. The congressional proposal would create a single conversion factor of \$35.42 for 1996.

Updates to the conversion factor are based on volume growth currently regulated through the Medicare Volume Performance Standard (MVPS). The MVPS is a spending goal for Part B services and is established by Congress or by a statutory default formula if Congress chooses not to act.⁶ The default formula is linked to changes in the Medicare Economic Index (MEI) intended to measure the annual growth in physicians' practice costs and general inflation in the cost of operating a medical practice.⁶ The MVPS has a two-year delay; for example, it reviews data from 1993 to determine the 1995 update.

The congressional reconciliation package seeks to replace the MVPS with a sustainable growth rate system (SGR) combined with a fail-safe mechanism. The proposal would continue to determine conversion factor updates based on volume growth, but the growth target, the SGR, would be based annually on changes in enrollment, changes in the MEI, and changes in the gross domestic product plus 2 percentage points. Updates to the conversion factor, dependent on the level of volume growth, would be based on the MEI, but be limited to no more than 103 percent, and no less than 93 percent, of MEI.

The Physician Payment Review Commission has analyzed the potential impact of the proposed changes. An estimate of the average change in payment by specialty, using the 1996 proposed conversion factor of \$35.42, concludes that cardiology would see a 1.4 percent increase, family/general practice a 1.1 percent decrease, thoracic surgery an 8.4 percent decrease, general surgery a 6.4 percent decrease, and pathology a 2.3 percent increase.⁷ The long-term impact on reimbursement is likely to be positive if growth rates are relatively modest; however, if growth significantly exceeds the target, reductions in the conversion factor are likely. Some analysts are concerned that the potential for

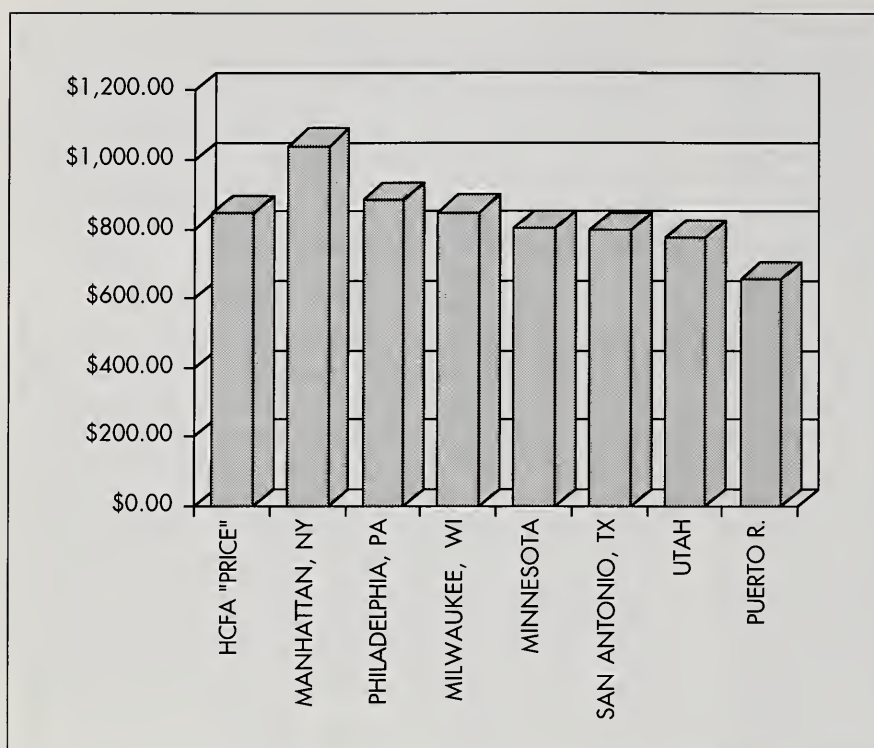


Figure 3—1995 RBRVS gallbladder removal payment rates for selected locations.
Note: 1995 C.F. and 1996 GPCIs.

reduced reimbursement could create incentives for physicians to limit the number of fee-for-service Medicare patients they see.

Of concern to Minnesota physicians is the geographic variation in fee-for-service payment rates. The RBRVS is a national fee schedule, but payments are adjusted for geographic differences in costs. The legislation establishing the RBRVS required HCFA to retain the payment areas that existed under the previous customary, prevailing, and reasonable payment system, unless a state petitioned for a change. Minnesota converted its three former payment areas into a single payment area in 1992, the first year of RBRVS implementation.

To adjust RBRVS payments across payment areas, HCFA calculates geographic practice cost indices (GPCIs), which measure the cost of running a medical practice in each of the nation's 210 different payment areas relative to a national average. The components of the GPCIs are the same as the components of the RBRVS—work, practice, and malpractice. The practice and malpractice components must reflect the full differential between the payment area and the national average; the work component can reflect only one-quarter of the differential.

The RBRVS is intended to objectively measure the resource costs associated with each medical service; therefore, HCFA uses proxy data to calculate practice costs to avoid creating a system that becomes driven by physician costs. The data HCFA uses to calculate work costs include a 20 percent sample of median hourly earnings of six professional occupations from the 1990 census. For practice costs, it uses 1990 census data of the salaries of medical and clerical occupations and fair

market rental data for residential (not commercial) sites. The malpractice rates are based on a three-year average (1990 to 1992) of actual physician malpractice premium data.

Although HCFA defends the data used to calculate the GPCIs, many physicians and policy analysts have questioned the data's validity. Figure 3 illustrates some of the variation in reimbursement for one procedure—a gallbladder removal. The difference in payment is entirely due to differences in local costs as measured by the GPCIs.

Equally frustrating for many physicians is the large number of payment districts that exist without any economic rationale. Most of the 210 existing payment areas are identical to those from the customary, prevailing, and reasonable payment system and do not necessarily represent economically distinct areas with substantial differences in practice costs. For example, Texas has 32 separate payment areas, Wisconsin has 11, while

Minnesota has only one.

Although HCFA has authority to change payment areas, its policy requires that any changes in payment areas must have widespread support of the physician community. Some states that are interested in a statewide payment area, such as Wisconsin, have not been able to garner support from physicians, primarily those in urban areas, who are likely to see reduced payments.

The congressional Medicare proposal did not include any changes to the GPCIs or the fee-for-service payment areas.

MEDICARE RISK CONTRACT PROGRAM: THE PRECURSOR TO MEDICAREPLUS

By the early 1970s, Congress, facing rising Medicare costs and limited resources, joined business and other payers of health care services in identifying broad financing alternatives to traditional fee-for-service health care. In 1972, Congress recognized the potential for cost savings through HMOs or competitive medical plans (CMPs) and amended the Social Security Act.⁸

Public Law 92-603 provided prepayments to HMOs serving Medicare beneficiaries; the payment policy implemented, however, offered few incentives for HMO participation and, consequently, did not achieve the anticipated reduction in costs. Problematic provisions included the requirement that any profits earned by the HMO (capped at 10 percent of the total payments received) were to be shared with HCFA; the financial risk facing the HMO was unlimited.

In 1982, Congress changed the payment mechanism and created the Medicare risk contract program.⁹ The changes in the law were incorporated into section 114 of

the Tax Equity and Fiscal Responsibility Act (TEFRA); consequently, the risk contract program is often referred to as the TEFRA risk contract program. The new payment policy, implemented in 1985, was developed not only to encourage HMO participation and, ultimately, cost-savings, but also to recognize and compensate for the risk assumed by participating HMOs.³ Medicare's risk contract program is an alternative to traditional fee-for-service Medicare. The option is available to nearly all beneficiaries⁵ but is used by only about 9 percent of them.¹⁰

INCREASED CHOICE AND RISK ADJUSTMENT

A multiple-choice scenario creates the risk of segmentation. According to data from the National Medical Expenditure Survey, more than half of all health care expenditures are accounted for by just 5 percent of the population.¹¹ If individuals were randomly assigned to all health insurers, the distribution of high consumers of health care or the distribution of risk (i.e., high-cost individuals) is expected to be equivalent among all insurers. In a competitive, multiple-choice marketplace, however, an unequal distribution of risk is likely to occur. This phenomenon is known as biased selection or risk selection.¹²

Risk selection occurs as a result of intentional and unintentional actions by both insurers and the insured. If an insurer enrolls more of the healthy, low-risk individuals, favorable selection is said to have occurred because average costs are below payments received. If an insurer enrolls more of the sick, high-risk individuals, adverse selection is said to have occurred because average costs are above payments received.^{12,13}

Two primary policy options are available to avert or minimize risk selection—regulation and risk adjustment.⁴ Regulation and competition must be balanced; competition creates incentives to provide health care coverage only to the limited numbers of high-risk individuals who can afford the price of coverage, and regulations alone (e.g., guaranteed issue and rating restrictions) create incentives to avoid high-risk individuals entirely.

Another policy option is the use of risk adjustment to provide insurers with the equal opportunity for financial gain regardless of risk corresponding to the population enrolled. Risk adjustment is not widely used in the U.S. health insurance market beyond the Medicare program. Medicare currently uses two methods to minimize risk selection—administrative policies and risk adjustment.

Administrative policies like the following are designed to minimize HMOs' ability to perform risk selection: 1) HMOs may not refuse enrollment to an individual because of a medical condition; 2) HMOs must have an annual, 30-day open-enrollment period; 3) HCFA reviews HMOs' marketing and recruiting practices; and 4) Medicare beneficiaries may cancel enrollment from an HMO at any time by giving written notice to the HMO or to Medicare.⁸

Medicare also uses a demographic risk-adjustment mechanism incorporated in its payment formula, the adjusted average per capita cost (AAPCC). In an effort to distribute the systematic risk of Medicare enrollees, payments are adjusted according to beneficiaries' age, sex, Medicaid eligibility, and institutional status. The AAPCC formula assumes that health care use varies by these factors.

If the risk adjustment incorporated in the AAPCC formula accurately calculated the non-random costs, there would be little, if any, risk selection in the Medicare risk contract program. Despite the presence of a risk-adjustment mechanism, numerous studies have concluded that Medicare HMOs do, in fact, experience favorable selection.¹⁴⁻¹⁸ As a result, the risk contract program has increased Medicare costs by an estimated 5.7 percent to 28 percent above the costs had the individuals remained in the fee-for-service Medicare program.⁸ Cost increases occur when HMOs experience favorable selection.

Costs can also increase in the Medicare program as a result of the way the capitation rate is calculated. The AAPCC is based in part on cost and utilization in the fee-for-service program. As healthy individuals join HMOs, the costs upon which the capitation rates are set may be from sicker, more costly individuals, thereby increasing the capitation rate for the more healthy individuals covered under HMOs. Ideally, a risk-adjusted capitation rate would give HMOs the financial resources necessary to provide services to beneficiaries equivalent to their health care needs. If such a rate could be calculated, an HMO's incentive to enroll only healthy, low-risk individuals would be significantly reduced.

The conclusion among most researchers is that the demographic risk adjustment incorporated in Medicare's AAPCC formula is extremely limited and should be expanded to include some measure of health status.¹⁹⁻²¹

The congressional proposal would not have changed the risk-adjustment mechanism used in the Medicare program. Although HCFA has the authority to change risk adjustment, it has been reluctant to implement widespread change.

MEDICAREPLUS PAYMENT RATES

The AAPCC is the current payment or capitation rate calculated by HCFA and paid to Medicare HMOs. Because Congress saw the use of HMOs as a means to control program expenditures, the legislation establishing the risk contract program required that payment to HMOs be equal to 95 percent of the average cost of treating the patient in the fee-for-service sector. In other

‡HMOs can serve Medicare patients through four programs: the risk contract program, a cost contract program, health care prepayment plans, and a social HMO. This discussion is limited to the risk contract program.

§End-stage renal disease patients are not eligible for the risk contract program unless they were an HMO enrollee at the time they became eligible for Medicare.

¶Reinsurance is another policy option sometimes discussed. Here, reinsurance is viewed as a type of risk adjustment mechanism.

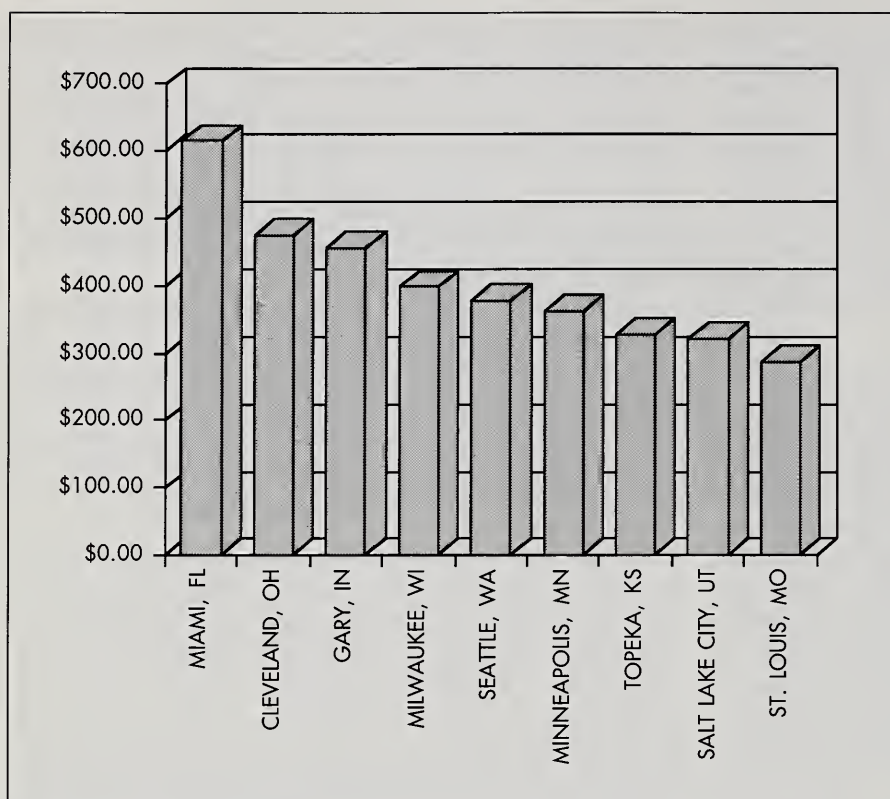


Figure 4—1995 AAPCC rates for selected U.S. cities.

words, it was assumed that HMOs would, at a minimum, result in savings of approximately 5 percent per beneficiary. The TEFRA provisions eliminated the requirement that HMO profits from the Medicare line of business be shared with HCFA. Instead, HMOs were now allowed to keep all profits up to the level earned on their non-Medicare business; this amount is known as the adjusted community rate (ACR).⁸ If estimated profits from the Medicare risk contract exceed estimated profits on the non-Medicare business, the excess dollars must be passed on to the enrollees in the form of reduced copayments, deductibles, or additional benefits, or refunded to HCFA.

HCFA uses three primary steps to calculate the risk contract payment rate. First, it calculates the U.S. per capita cost (USPCC), a national estimate of per capita costs utilizing three years of Medicare historical spending data. Separate costs are calculated for Part A and Part B services for the aged, the disabled, and for persons with end-stage renal disease. Second, HCFA adjusts the USPCC for geographic differences in Medicare expenditures (using a five-year moving average of fee-for-service claims data) to derive county-specific rates for Part A and Part B services for the elderly and the disabled; statewide rates are estimated for end-stage renal disease patients. Third, the county-specific rates are adjusted by risk based on demographic features—age, sex, institutional status, and Medicaid status. This figure is the county-specific payment rate, of which Medicare pays 95%.

The proposed congressional legislation preserved the bulk of the AAPCC methodology for calculating payment rates for MedicarePlus plans, but updates to the

rate were capped at an average of 5.7 percent per year.

GEOGRAPHIC VARIATION

In addition to the criticisms of the AAPCC for its limited risk-adjustment mechanism, the AAPCC has also been criticized because of its wide variation in payment rates.

According to HCFA Region V, Managed Care Division, as of October 1, 1995, there were three Medicare risk contracts in effect in Minnesota, covering approximately 59,000 beneficiaries, or about 9 percent of the total Medicare population in Minnesota. These are relatively low numbers given the penetration of managed care in Minnesota's private sector. One of the primary explanations given for the relatively low levels of risk contract enrollment in Minnesota is the low level of reimbursement—a result of the price variation and structure of the AAPCC payment formula.

The AAPCC, as a county-level payment based on historical Medicare fee-for-service costs, is a reflection of differences in the prices of local medical services and in the utilization of those services. If there are barriers to care for fee-for-service beneficiaries (e.g., lack of physicians in a rural area), the low utilization will be reflected in the AAPCC rates for that county; if beneficiaries in a county utilize a large quantity of services (e.g., increased demand, inefficient medical care), the high utilization will be reflected in high AAPCC rates.⁸

Minnesota has consistently prided itself on its quality care and efficient health care delivery systems. This efficiency, it is argued, has resulted in payments that penalize, rather than reward, cost-conscious health care delivery. Some researchers have argued that markets with high levels of managed care have lower fee-for-service costs because both sectors become more efficient.²² Given the AAPCC's link to fee-for-service costs, Minnesota is possibly being penalized for controlling costs and utilization. Other researchers, however, have suggested that increased market penetration by HMOs leads to higher fee-for-service costs because the relatively unhealthy tend to remain in the fee-for-service sector.⁸ Regardless of the reasons, Minnesota's AAPCC rates have not been high enough to encourage HMO participation to the degree one might expect in this market. In addition, as shown in Figure 4, the rates are in dramatic contrast to those paid in other cities.

In an effort to ameliorate the variation in payment rates, and in order to encourage participation of managed care plans in the MedicarePlus program, the congressional reconciliation bill altered the payment formula slightly. Although counties remain the primary

payment areas for calculating rates, states can request a change to either a single statewide rate or to payment areas based on metropolitan statistical areas, thereby reducing the variation among neighboring counties. The proposal also set a minimum monthly payment rate equal to the greatest of one of the following 1) \$300 in 1996 and \$350 in 1997 (note that the 1995 AAPCC rates in Minnesota were below \$300 in all but 13 counties); 2) a 2 percent increase over the previous year's rate; or 3) a blended capitation rate made up of an area-specific and national rate.

CONCLUSION

The presidential veto of the budget plan sets the stage for intense negotiating. The traditional Medicare fee-for-service program and the new MedicarePlus concept will likely be key components of any final agreement. Minnesota physicians and their patients have a stake in the outcome of the negotiations and should be informed of the issues involved to help effect sound public policy.

MM

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REFERENCES

1. Social Security and Medicare Boards of Trustees. Status of the Social Security and Medicare programs: a summary of the 1995 annual reports. Washington, D.C.: Social Security and Medicare Board of Trustees, 1995.
2. Health Care Financing Administration. Medicare and Medicaid supplement. Health Care Financ Rev 1995;16(supl):26-33,158-87.
3. Davis K. Medicare solvency and financial security for beneficiaries: testimony before the U.S. Senate Budget Committee, May 3, 1995. In: Medicare's 30th anniversary. Washington, D.C.: Democratic Policy Committee, U.S. Senate, 14 July 1995.
4. Bureau of National Affairs. Health care policy report: Medicare provisions (Title VIII) of conference report on Omnibus Budget Reconciliation Bill (HR 2491). Washington, D.C.: Bureau of National Affairs, 20 November 1995.
5. Bureau of National Affairs. Health care policy report. Washington, D.C.: Bureau of National Affairs, 27 November 1995.
6. American Medical Association. Medicare RBRVS: the physicians' guide. Chicago: American Medical Association, 1995.
7. Spock M. PPRC estimates: pathologists win, thoracic surgeons lose with 1996 CF. Part B News 1995;9(22).
8. U.S. General Accounting Office. Medicare changes to HMO rate setting method are needed to reduce program costs. Washington, D.C.: General Accounting Office, 1994:12-39. Report 94-119.
9. P.L. No. 97-248, 96 Stat. 341.
10. Physician Payment Review Commission. Annual report to Congress. Washington, D.C.: Physician Payment Review Commission, 1994.
11. Berk M, Monheit A. The concentration of health care expenditures: an update. Health Aff 1992;11(4):145-9.
12. Minnesota Department of Health, Minnesota Department of Commerce. Risk adjustment. Minneapolis: Minnesota Department of Health, 1995.
13. Luft H. The self-selection issue. In: Health maintenance organizations: dimensions of performance. Washington, D.C.: John Wiley and Sons, 1981.
14. Brown R, Hill J. Biased selection in the TEFRA HMO/CMP program: report to HCFA. Washington, D.C.: Mathematica Policy Research, Inc., 1990.
15. Eggers P. Risk differential between Medicare beneficiaries enrolled and not enrolled in an HMO. Health Care Financ Rev 1980;1(3):91-9.
16. Eggers P, Prihoda R. Pre-enrollment reimbursement patterns of Medicare beneficiaries enrolled in 'at-risk' HMOs. Health Care Financ Rev 1982;4(1):55-73.
17. Brown R, Bergeron J, Clement D, et al. Does managed care work for Medicare? an evaluation of the Medicare risk program for HMOs. Washington, D.C.: Mathematica Policy Research, Inc., 1993.
18. Lubitz J, Beebe J, Riley G. Improving the Medicare HMO payment formula to deal with biased selection. In: Scheffler R, Rossiter L, eds. Advances in health economics and health services research. Greenwich, Connecticut: JAI Press, 1985:101-22.
19. McClure W. On the research status of risk-adjusted capitation rates. Inquiry 1984;21(3):205-13.
20. Thomas JW, Lichtenstein R. Functional health measures for adjusting health maintenance organization capitation rates. Health Care Financ Rev 1986;7(3):85-95.
20. Newhouse J, Manning W, Keeler E, Sloss E. Adjusting capitation rates using objective health measures and prior utilization. Health Care Financ Rev 1989;10(3):41-53.
22. Welch P. HMO market share and its effect on local Medicare costs. Washington, D.C.: The Urban Institute, 1992.

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People and Places Making Medical News

People

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Assistant Commissioner of Health

Mike Moen, M.P.H., has been appointed assistant commissioner of health for the Bureau of Health Protection, Minnesota Department of Health. In his new position, he will oversee disease prevention and control, public health labs, and environmental health. Moen has a particular interest in emerging infectious diseases, the projected increase in chronic diseases and conditions resulting from an aging population, the relationship between health and environment, and the public health infrastructure.

Moen has been director of the Division of Disease Prevention and Control since 1984. He joined the Minnesota Department of Health in 1974.

Multiple Sclerosis Society Recognition

The Minnesota Multiple Sclerosis Society has recognized **Randall Schapiro, M.D.**, of Minneapolis for his volunteer achievement. Schapiro has been a member of the MS Society board of directors since 1976 and is also chair of the Professional Advisory Committee. He gives lectures on multiple sclerosis to professional and community groups and serves on the National Medical Advisory Board.

Planned Parenthood First Annual Physician Award

Mildred S. Hanson, M.D., Planned Parenthood of Minnesota's medical director for the past 23 years, has received the organization's first annual Physician of the Year Award in recognition of her years of service.

"Dr. Hanson is truly a pioneer in women's health care and has played a significant role in the

research on virtually every method of prescription and nonprescription contraception available today," said Thomas P. Webber, executive director of Planned Parenthood of Minnesota.

The award, which recognizes extraordinary service and dedication to the organization, will be presented each year to a physician working for Planned Parenthood of Minnesota.

Places

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Mayo Connects With Jordan

Mayo has launched a video communications link with the King Hussein Medical Centre and Amman Surgical Hospital in Jordan. Through this electronic telemedicine link, physicians and patients will communicate face-to-face even though they are almost 7,000 miles apart. Jordanian patients can consult with or get a second opinion from a Mayo physician without traveling to the United States. Telemedicine connects the two Jordanian health care facilities with Mayo's three sites in Rochester, Minnesota; Jacksonville, Florida; and Scottsdale, Arizona.

In 1992, Jordanian physicians visited Rochester to discuss ways in which Mayo could help enhance health care in their country. At the request of Jordanian health care organizations, Mayo set up the link. The rooms are equipped with television monitors, a video camera mounted above the patient examination table, and special equipment that allows Mayo physicians to conduct patient evaluations.

In addition to telemedicine, Mayo has installed videoconferencing equipment in an auditorium at King Hussein Medical Centre and will begin broadcasting interactive, bimonthly medical education programs this month. Mayo has

already planned programs on bone marrow transplantation, breast cancer, and heart rhythm disturbances.

Abbott to Open Health Center for AIDS Patients

Abbott Northwestern Hospital plans to open a day health center for AIDS patients. The new center, scheduled to open in June, will provide a number of services, including nursing care and medication management; health education for patients and their caregivers; occupational, physical, and massage therapy; and psychological services and counseling to about 30 AIDS patients too sick to be home alone but not sick enough to be hospitalized.

The center will be located on the first floor of the 65-room Franklin Crosby mansion at 2120 Park Avenue South, which is being provided by the Archdiocese of St. Paul and Minneapolis.

"People who are living with AIDS and the people they depend on for care need more options, and a day health center is an innovative, compassionate, safe, and cost-effective environment," said Bishop Lawrence Welsh of the archdiocese in a *Twin Cities Star Tribune* article.

Project organizers have raised \$300,000—\$100,000 each from Abbott Northwestern, Allina Health System, and the federal Department of Housing and Urban Development. However, hospital officials say the center won't open until they raise an additional \$500,000 to renovate the mansion and \$2.1 million for an endowment to operate the center. Abbott plans to lead the fund-raising campaign.

Obesity Research Center

The National Institutes of Health is funding a Minnesota Obesity Center to conduct research on

obesity. The center, one of four in the United States, will comprise 30 medical experts from the Veterans Affairs Medical Center, the University of Minnesota, and the Mayo Clinic in Rochester. Hennepin County Medical Center will also recruit some subjects for research trials to assure racial balance. NIH will provide \$869,000 in funds for each of the next five years. The three other NIH-funded centers are located in Boston, New York, and Pittsburgh.

The research will be divided into four groups. One, led by James Mitchell III, M.D., a professor of psychiatry at the University of Minnesota, will evaluate people with eating disorders to determine whether overeating or undereating is caused by an illness or illnesses. A second group, led by the Mayo Clinic, will evaluate how much food obese people actually eat (compared with how much they think they eat). Group three will study the molecular biology of obesity to see if there really are obesity genes and if identifying them can lead to ways to prevent obesity. The fourth group, led by epidemiologist Robert Jeffrey, Ph.D., at the University of Minnesota School of Public Health, will search for clues to the cause of obesity and how to prevent it.

Obesity is the most common nutrition problem in the United States, but efforts to treat it have been almost completely unsuccessful. "Obesity is second only to cigarette smoking as a cause of premature death in the United States," said Allen S. Levine, Ph.D., the Minneapolis Veterans Affairs Medical Center researcher who directs the new center.

'U' Receives Research Grant to Study Health Care Market Changes

The University of Minnesota is among 10 centers recently awarded research grants from the Agency for Health Care Policy and Research to study the changes reshaping America's health care system as a result of complex market forces.

The university's \$128,000 grant will fund a study on how horizontal hospital mergers affect efficiency, profitability, and consumer prices.

The agency's grants to the 10 centers totaled \$1.4 million for the first year. Most of the projects will be completed in two years or less.

continued

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GHAA Awards HealthPartners' Childhood Immunization Program

HealthPartners' Childhood Immunization Program is the first place gold medal winner of the Celebrating Innovation Award, Continuous Quality Improvement Category, sponsored by the Group Health Association of America (GHAA). Competing in the category were Harvard Community Health Plan of Brookline, Massachusetts; United HealthCare of Minneapolis; and Lifeguard of Milpitas, California.

HealthPartners improved its pediatric immunization rates from 56 percent to 87 percent since implementing new guidelines and recommendations under the team leadership of James Nordin, M.D., Larry Condon, M.D., Emma Carlin, M.D., Nancy Waldoch, R.N., Eileen McKenna, Nancy Olson, Linda Keiser, and Rick Carlson. Protocols now include improved recordkeeping through a computerized vaccination registry, clarification of immunization status at every pediatric appointment, and the enhancement of patient/parent responsibility for vaccinations.

BCBSM Launches Consumer Information Centers

Blue Cross and Blue Shield of Minnesota has developed a touch-screen computer system to provide consumers with profiles of physicians, clinics, and pharmacies, as well as wellness information. The company has installed the system in a free-standing kiosk at the corporate offices of a major Twin Cities employer. It is monitoring use and gathering feedback from users through a touch-screen questionnaire, which it will use to evaluate the system.

In addition to information on clinic hours, hospital affiliations, and directions, users can view photos of clinics and listen to information on the clinics' unique characteristics. Users also can learn more about physicians, including their gender, medical specialties,

and languages spoken, or they can explore topics such as back pain, cancer, or the flu. In addition, they can print out preventive health guidelines specific to their age and gender.

Socioeconomics

United HealthCare Buying North Carolina HMO

United HealthCare Corp. is buying PHP Inc., North Carolina's third-largest HMO, for \$142.2 million. United has managed the HMO for 10 years. PHP has more than 117,000 members and more than 3,000 providers and 45 hospitals in its network.

United HealthCare also is planning to develop a managed care network in Virginia with the state's medical society. United will jointly own the organization with an entity established by the Virginia Medical Society.

Albert Lea's Naeve Health Care Association Joining Mayo

Naeve Health Care Association Board of Trustees and membership have agreed to a proposal that will make Naeve Health Care of Albert Lea, Minnesota, part of the Mayo Health System and will later merge Naeve with the Albert Lea Clinic. Together, the three groups plan to develop a health care delivery system that will provide care to patients in Albert Lea and the surrounding area, and they eventually plan to form an integrated medical center. Initially, Naeve Hospital in Albert Lea will be the site of a new oncology treatment center developed by Mayo, while planning will begin for developing a new outpatient facility to house the Albert Lea Clinic and other services from the Naeve Hospital.

North Memorial Forming Physicians Organization

North Memorial Health Care, Primary Care Partners-Northwest, and North Physicians Organization are forming a new physician organization called North Physi-

cians Health Organization (NPHO) to serve the northwest Twin Cities metro area. Forming the alliance, which will include more than 200 physicians at about three dozen locations, will allow the groups to pool financial and strategic resources without losing operational control. The groups plan to develop a computer system that allows patients' records to follow them wherever they go and to jointly market their services to health plans and other health care purchasers.

North Memorial runs North Memorial Medical Center in Robbinsdale, as well as nine clinics in the area. Primary Care Partners-Northwest is a consortium of 90 doctors from four primary care clinics, and North Physicians Organization is a group of 100 specialists who practice at North Memorial.

Rates, Trends, Data

Minnesotans Putting On Weight

Minnesotans are gaining weight, according to a 10-year University of Minnesota study, even in three cities where residents were given information about how to eat properly. The study results were unexpected but similar to national data that show U.S. obesity rates climbed 40 percent during the 1980s, said Robert Jeffrey, an epidemiology professor at the university who worked on the study, in a Twin Cities *Star Tribune* article. The researchers didn't analyze reasons for the weight gains, but they suspect that the growing popularity of fast-food restaurants and more time spent in front of the TV and computer are primary factors.

As part of a larger study called the Minnesota Heart Health Program, researchers from the university's School of Public Health monitored the weights of residents from 1980 to 1990 in six communities: Bloomington, Mankato, Fargo-Moorhead, Roseville,

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Chevrolet Suburban 4x4 LS	\$35,838	\$32,819	\$472	\$446	\$412	\$412
Dodge Grand Caravan LE	\$27,880	\$25,555	\$468	\$409	\$379	\$352
Toyota Corolla 4Dr DX	\$18,010	\$16,288	\$267	\$242	\$264	\$253
Ford Explorer XLT 4Dr 4WD	\$28,835	\$26,200	\$416	\$380	\$359	\$344
Honda Civic 4Dr LX	\$16,230	\$14,955	\$256	\$226	\$208	\$206
Mercury Sable LS	\$22,780	\$21,075	\$424	\$379	\$348	\$327
Jeep Grand Cherokee Laredo	\$30,199	\$27,751	\$472	\$414	\$393	\$385

* Sale price before tax, license, and license fees. Prices and lease rates are subject to change due to adjustments made by manufacturers and finance companies.

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Winona, and Sioux Falls. When adjusted for age and other factors, the results showed that residents in all six communities gained between 6 and 10 pounds during the study, even though residents of the first three cities were given extensive instructions on proper diet and exercise.

Cigarette smoking decreased by about one-third for the six communities, and cholesterol levels were down slightly each year. Blood pressure readings remained stable.

Poll Shows Many Kids Are Abused

A Gallup Poll of 1,000 parents nationwide estimates that more than 3 million children are physically abused each year in the name of discipline. An estimated 5 percent of parents punish their children by punching, kicking, or throwing them down, or hitting them with a hard object on some part of the body other than the bottom. Gallup classified those acts

as abusive; punishments such as spanking, slapping, shouting, cursing, or threatening to send a child away were not considered abusive in the study.

Gallup also estimates that about 1.3 million children are sexually abused each year. Instead of asking respondents whether they sexually abused their children, the poll asked whether, as far as respondents knew, their children had been forced to have sex with an adult or older child, had been forcibly touched sexually by an adult or older child, or had been forced to touch sexually an adult or older child.

The Gallup estimates are much higher than the federal government's statistics, which are based on reported and confirmed abuse. The National Center on Child Abuse and Neglect's 1993 report says that more than 200,000 children were victims of physical abuse, and government statistics say 130,000 children are victims of sexual abuse.

Teen Smoking Up, Drinking Down

Minnesota kids are smoking more than the national average, according to the 1995 Minnesota Student Survey of 133,000 students in the sixth, ninth, and 12th grades conducted by the Minnesota Department of Children, Families and Learning. Compared with 31 percent nationwide, 39 percent of Minnesota seniors said they smoked at least once in the past month. Smoking among Minnesota teens has increased since the last survey was conducted in 1992. One-fourth of all high school seniors said they smoke at least once a week, compared with 22 percent in 1992; 18 percent of students in the ninth grade smoke once a week, compared with 12 percent in 1992.

The good news is students are less likely to drink alcohol, have sex, become a victim of physical abuse, get into fights, or to commit vandalism. However, the survey found a greater number of students have attempted suicide, smoked marijuana, and shoplifted.

Minnesotans Drink More than National Average

Alcohol consumption in Minnesota is higher per capita than the national average and contributed to 1,581 deaths and costs of about \$1.74 billion in 1991, according to a study by the Minnesota Department of Health. That year, the average drinker in Minnesota consumed about 83 glasses of wine, 288 shots of liquor, and 453 beers—the equivalent of more than two drinks per day.

About 45 percent of the alcohol-related deaths were from chronic medical conditions, such as cancer, digestive disease, and cardiovascular disease. About 41 percent were the result of injuries or violence. The cost figure includes direct health care costs, lost income because of premature death and illness, the cost of treating people with fetal alcohol syndrome, and other costs unrelated to health, such as crime.

The study also found that binge drinking is a serious problem in Minnesota, especially among young men. During both 1992 and 1993, about 20 percent of Minnesotans surveyed reported episodes of binge drinking, defined as consuming five or more standard servings of alcohol on at least one occasion in the past month. Minnesota came in fifth nationally for the number of residents who binge drink, and Wisconsin came in first. The national median was about 14 percent. The problem is worse among younger men; between 1989 and 1993, 52 percent of Minnesota men between ages 18 and 24 reported binge drinking, according to Kim Miner, a research scientist who helped compile the report.

Law & Policy

Court Throws Out Preston Tobacco Ad Ban

A federal court has thrown out a Preston, Minnesota, ordinance that banned all brand-specific tobacco advertising and promotional items

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in the town's retail stores. The southeastern Minnesota town's government passed the ordinance, which took effect in June 1994, because it believed the ads encourage youth to smoke.

Binh Chiglo, owner of the Citgo One Stop in Preston, sued after the city threatened legal action when she failed to remove all cigarette ads in her store. She said the ordinance violated her state and federal rights of free speech. Although the verdict did not mention free-speech rights, U.S. District Judge Paul Magnuson said the federal requirement that warning labels be included on cigarette packages preempts state and local laws regarding cigarette advertising.

3M and Other Companies Settle Breast Implant Class-Action Suit

3M and two other companies have settled a class-action suit by women who have had silicone breast implants. The settlement will

cost the companies \$2 billion to \$3 billion if all eligible women participate, but it replaces an even higher settlement of \$4.25 billion agreed to in late 1993. That settlement collapsed.

3M manufactured breast implants from 1977 to 1984. The other companies in the settlement are Bristol-Myers Squibb Co. and Baxter Healthcare, a subsidiary of Baxter International. Dow Corning Corp., a breast implant manufacturer jointly owned by Dow Chemical and Corning Inc., is not part of the new agreement because it has filed for bankruptcy.

The settlement awards will range from \$10,000 to \$250,000, depending on the women's ages, their degree of illness, and how much medical data they submit. Lawyers representing the women with implants say the devices cause a wide variety of illnesses, including vague aches and pains, fatigue, autoimmune diseases, and neurological disorders. The companies

say there is no evidence that the devices cause diseases; they say they were forced to settle because of the great number of lawsuits.

In San Antonio, Texas, a judge recently declared a mistrial in another case filed against 3M over silicone breast implants. Sharon Ann Gamblin sued 3M and plastic surgeon Tolbert Wilkerson for \$40 million because she said ruptures and leaks from her implants caused her permanent health problems. She had opted out of the settlement in the class-action suit. After the month-long trial, the jury became deadlocked 9-3 in favor of the defendants. A vote of at least 10-2 was needed for a verdict.

MM

KAREN TA

(continued from page 7)

physicians, but psychologists, nursing staff, and social workers, as well. "I like dealing with the other aspects of the patient's life, including their psychosocial environment, rather than just the medical side of things."

In addition to her work at Ramsey, Ta works part time at the Center for Victims of Torture in Minneapolis. Her involvement with the center began in 1993, when she simultaneously completed her third-year psychiatric residency at the University of Minnesota and a fellowship in cultural psychiatry at both the center and Ramsey's International Clinic. At the Center for Victims of Torture, Ta evaluates and treats victims of torture and political persecution primarily from countries in Asia, Africa, and Central America. Similar to patients at Ramsey's International Clinic, many of the torture victims are refugees. Others are in the United States seeking political asylum.

As in Ta's other psychiatric work, a multidisciplinary team—including psychiatrists, psychologists, internal medicine or family physicians, nurses, and social workers—provides treatment for the torture victims. "There are obvious physical consequences of torture and immediate health needs that must be met [in treating the victim]," says Ta. "But there are also psychological consequences, and team members are there to provide therapy and to help meet [the victim's] other social needs."

What motivates Ta in her work is the belief that she can make a difference in the lives of the people she treats. She is hopeful about their individual situations, believing that with treatment, people can improve and learn to adapt to the stresses they face.

"Some people feel that it must be hard to be in the field of psychiatry, that it must be depressing to hear about other people's trauma and loss every day. But I know that by my listening to patients, they feel that their voices are being heard, and I try

to do my best to alleviate their emotional distress."

Many of Ta's patients suffer from depression and sleep problems, including nightmares resulting from trauma, Ta explains. Her ability to provide both psychological support and therapy, as well as medication to alleviate symptoms, can make a real difference in a patient's day-to-day life, she says.

To support and enhance the treatment she provides at the clinic level, Ta emphasizes that it is important for the hospital to form and maintain relationships with community organizations that can provide for a patient's nonmedical needs. For example, social service agencies can help a patient obtain housing, put food on the table, or find child care. Many organizations also have support groups, services for the elderly, and youth programs, as well as outreach services or home visits for patients who may need extra help or encouragement.

"For example, I worked with a young Vietnamese woman, a single mom with two young children, who needed help finding daycare for her kids so that she could take an ESL [English as a second language] class," recalls Ta, referring to her patients' many nonmedical needs. In addition to the problems many single mothers face, this woman was isolated by her inability to speak English, adding to her depression. "If a mother doesn't speak English, she needs time away from her kids to take classes and study, with the hope that she can acquire the language and eventually work and raise her family and be more independent." That's where community organizations can help, Ta says.

In turn, Ta makes herself available for consultation with community organizations that also have relationships with some of her patients. Occasionally, she is invited to attend a meeting with staff from a social service agency regarding one of those patients. These organiza-

tions are often able to provide Ta with pertinent background information about a patient she is seeing.

Today, Ta resides in Woodbury, and her parents and sister remain in the Twin Cities, as well. Aside from her work as a psychiatrist, she enjoys bicycling and competes competitively with the United States Tennis Association. She says she feels very lucky to have gotten to where she is today. "I hear stories of other refugees who went through so much more than I ever did, and I remind myself every day to appreciate what I have now."

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Katie Colón is a free-lance writer in Champlin, Minnesota, specializing in health care and disability-related subjects.

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PSYCHIATRY

(continued from page 13)

of paying bonuses to executives who denied care, allowing nonphysicians to make decisions about care, and refusing to pay for needed treatment. Elsewhere, managed care organizations have been sued by various entities attempting to change their operating methods for mental health care. Numerous articles in professional journals have also discussed the drawbacks of the managed care approach.

"There's fierce debate about this area," Caplan says. "Nothing's really been settled yet."

Mental health providers have a variety of concerns about managed care, says Caplan. Providers who had free rein under traditional fee-for-service models resent managed care's influence on their practice, he says. In addition, managed care plans either severely restrict mental health benefits or do not offer them at all. Caplan says psychiatrists also dislike man-

aged care organizations' emphasis on medication and triage systems that steer patients to psychologists or social workers instead of psychiatrists.

"In the old days, there might have been a hemorrhage of money, but now the pendulum has swung the other way. Now there may be too much control," Caplan says. "There needs to be balance. Right now, there doesn't seem to be."

In Minnesota, debate has been civil for the most part, says Manolis, because providers are well acquainted with the managed care concept. But that does not mean providers have kept their complaints quiet. In a Twin Cities newspaper article earlier this year, a group of psychologists told a reporter they lied to insurance companies in order to obtain what they thought was the proper care for patients. Other complaints about carve-out organizations, many of them similar in nature to the Rhode Island Health Department's concerns, have been raised in mainstream and alternative publications. In an April Twin Cities *Star Tribune* editorial, Minneapolis psychologist J. Kirby Ogden took aim at the quality of managed mental health care, describing patients who have come to him after disastrous experiences with managed care. He wrote:

"As it exists today, managed care holds down mental health costs [by] severely limiting the kind of care it provides enrollees. Large numbers of people in these plans continue to struggle with psychological difficulties because they are either inadequately or inappropriately treated under managed mental health care. Something is terribly wrong with a system that abandons so many people who are supposedly insured."

Other providers, such as Charles McCafferty, M.D., an independent psychiatrist in Minneapolis, are even more blunt. "[Managed care's] goal is not to provide quality of care, but to provide profits for stockholders. The bottom line is profit," he says. A native of Great Britain, McCafferty says managed care has not worked well for mental health in that country, and it won't work here, either.

Much of the conflict stems from how the goals of managed care trans-

late into care that differs dramatically from what is thought of as traditional mental health care, say many local psychiatrists. Typical of most managed care systems is the way in which Allina, Fairview, and Park Nicollet operate a type of triage system. Patients who feel they need mental health care assistance may be referred by primary care physicians to the organization's mental health care providers. Patients may also refer themselves.

But once in the system, Minnesota providers say, it's likely the patient's first encounter with a mental health care provider won't be with a psychiatrist. Instead, most patients seeking care within a managed care organization will initially see a psychologist, nurse, or social worker. Patients diagnosed with a serious problem usually are referred to a psychiatrist affiliated with or employed by the managed care organization. Even when patients do see a psychiatrist, their time with the psychiatrist tends to be severely restricted. In some cases, psychiatrists may be assigned to see four or five patients in an hour, says Beecher. And then, he adds, the psychiatrist's role may be limited to prescribing medication.

Despite his role at Preferred One, Beecher acknowledges that these patterns worry him. In July, he wrote an article for the state's *Mental Health Advocate* calling for managed care organizations to treat psychiatrists as more than mere medication managers. Beecher also says patients do not feel as if psychiatrists spend enough time with them when access is granted.

A brief patient encounter doesn't allow enough time for decision-making regarding medication, says Beecher. "It requires an ongoing interaction with the patient. And if you pile up patient [appointments] so they're stacked four, five in an hour, it creates a stressful environment for the psychiatrists and produces sub-quality evaluations."

While most mental health care providers acknowledge such shortcomings, many say managed care is working in Minnesota.

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nesota Psychiatric Society, Mayo Clinic psychiatrist Mark Hansen, M.D., has heard the grievances of practitioners coping with managed care. Although Hansen is concerned, he also says it's appropriate for providers to be aware of limited financial resources.

"I think patients do receive good quality care, but it is different in many ways from the kind of care they would have received years ago," Hansen says, noting the advances made in psychotropic medication since the late 1960s (see related article, page 14). "It behooves us all to be aware of costs."

Other providers share Hansen's view and point to dramatic increases in health care spending as evidence that all health care providers need to be aware of other factors when treating patients. Indeed, the cost to employers of providing health care per employee jumped from \$1,724 in 1985 to \$4,285 in 1993, according to a survey by the consulting firm of A. Foster Higgins & Co. In addition, health care spending now consumes 15 percent of the gross national product, compared with 5 percent in 1960.

COSTS, QUALITY, OUTCOMES

"Health delivery systems must respond to the questions posed by purchasers and stakeholders: What are we doing, is it working, and is it worth the cost?" says Nancy Bologna, a mental health administrator at Park Nicollet who also holds a doctorate in psychology. "These questions translate to accountability with respect to cost-effectiveness and the quality of care."

At Park Nicollet, Bologna is supervising a treatment redesign program. Based loosely on total quality management concepts, Bologna's proposal is designed to look at the care delivery system as a whole and gather input from everyone involved to make improvements. A critical tool is measuring outcomes and using scientific methods to gather information. Bologna's plan was published in the December issue of *Behavioral Healthcare Tomorrow*.

Numerous providers in managed care organizations have expressed in-

terest in the project, partly because of the need for hard, scientific proof of treatments' effectiveness, Bologna says.

"There is great potential for managed care organizations to improve care and outcomes," says Beecher, who is an advocate of using critical pathways in psychiatric care. At Preferred One, he and his colleagues are using the American Psychiatric Association's "Diagnostic and Statistical Manual" as a template to define disorders and include the expertise of various research centers to develop the guidelines. The result, he says, should be more accurate diagnoses.

Health care purchasers expect to see these kinds of improvements, but they also want controlled costs. If providers are unable to meet both of those needs, Bologna says, employers will take their business to providers who can.

At Allina, medical director Trangle says having providers work together allows the system to focus on wellness and prevention, a cost-effective approach. The system also brings mental health care closer to

where patients live. In addition, he says, data show that a large number of patients are satisfied with the care they've received at Allina's carve-out clinics and other facilities.

Still, Trangle acknowledges that managed care's foray into mental health care is far from complete. Organizations such as his, he says, face challenges in the coming years in treating patients who require long-term care, particularly those who might be joining managed care from government programs, such as Medicare and Medicaid. The fee-for-service system had troubles of its own, Trangle points out, saying providers and the public shouldn't dismiss managed mental health care before it's had a chance to prove itself.

"Society is going through a time of great transition," Trangle says. "It hasn't reached consensus as to what its expectations are in the mental health realm. Until then, this subject will continue to be controversial." ■■

J.P. Miller is a free-lance writer residing in southern Minnesota and covering the greater Twin Cities area.

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JANUARY 1996

Jan. 8-12 **Bone and Soft Tissue Tumors** Mayo Foundation; Mauna Lani Bay Hotel, Kohala Coast, Hawaii. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

FEBRUARY 1996

Feb. 2 **Duluth Clinic Sixth Annual Family Practice Conference** Duluth Clinic; Fitger's Spirit of the North Theatre, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Duluth, MN 55805; 218/725-3838.

Feb. 10-14 **Selected Topics in Internal Medicine** Mayo Foundation; Rancho Bernardo Inn and Resort, San Diego, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 22-23 **Burn Care Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Feb. 29-March 2 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MARCH 1996

Mar. 7 **Annual Gentle Journey Conference: Palliative Medicine's Approach to the Relief of Suffering** Twin Cities Hospices; Sheraton Inn-Midway, St. Paul, MN. CONTACT: Lee Cummins, 1450 Energy Park Drive, St. Paul, MN 55108; 612/232-2600.

Mar. 7-8 **Family Medicine Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 22 **Occupational Medicine Update** St. Paul-Ramsey Medical Center; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Sharon Kopp, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Mar. 28-29 **Critical Care 1996** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

APRIL 1996

Apr. 1-3 **Management Strategies in Complex Congenital Heart Disease** Mayo Foundation; The Pointe Hilton at Squaw Peak, Phoenix, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 12 **ENT for Primary Care Physicians** St. Paul-Ramsey Medical Center and HealthEast; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 13 **Minnesota Urological Society Spring Seminar: An Update on Pelvic Floor Dysfunction, Urinary Incontinence, and Female Urology** Minnesota Urological Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Apr. 18-19 **Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 19-20 **Minnesota Orthopaedic Society 12th Annual Meeting** Minnesota Orthopaedic Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Apr. 25-26 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

Apr. 26-27 **Advances in Polycystic Ovary Disease** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

JUNE 1996

June 25-29 **Internal Medicine 1996: Advances and Controversies** Mayo Clinic and the Department of Medicine, Royal College of Surgeons, Ireland Medical School; Dublin, Ireland. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

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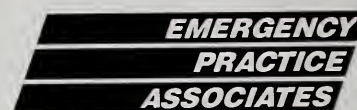
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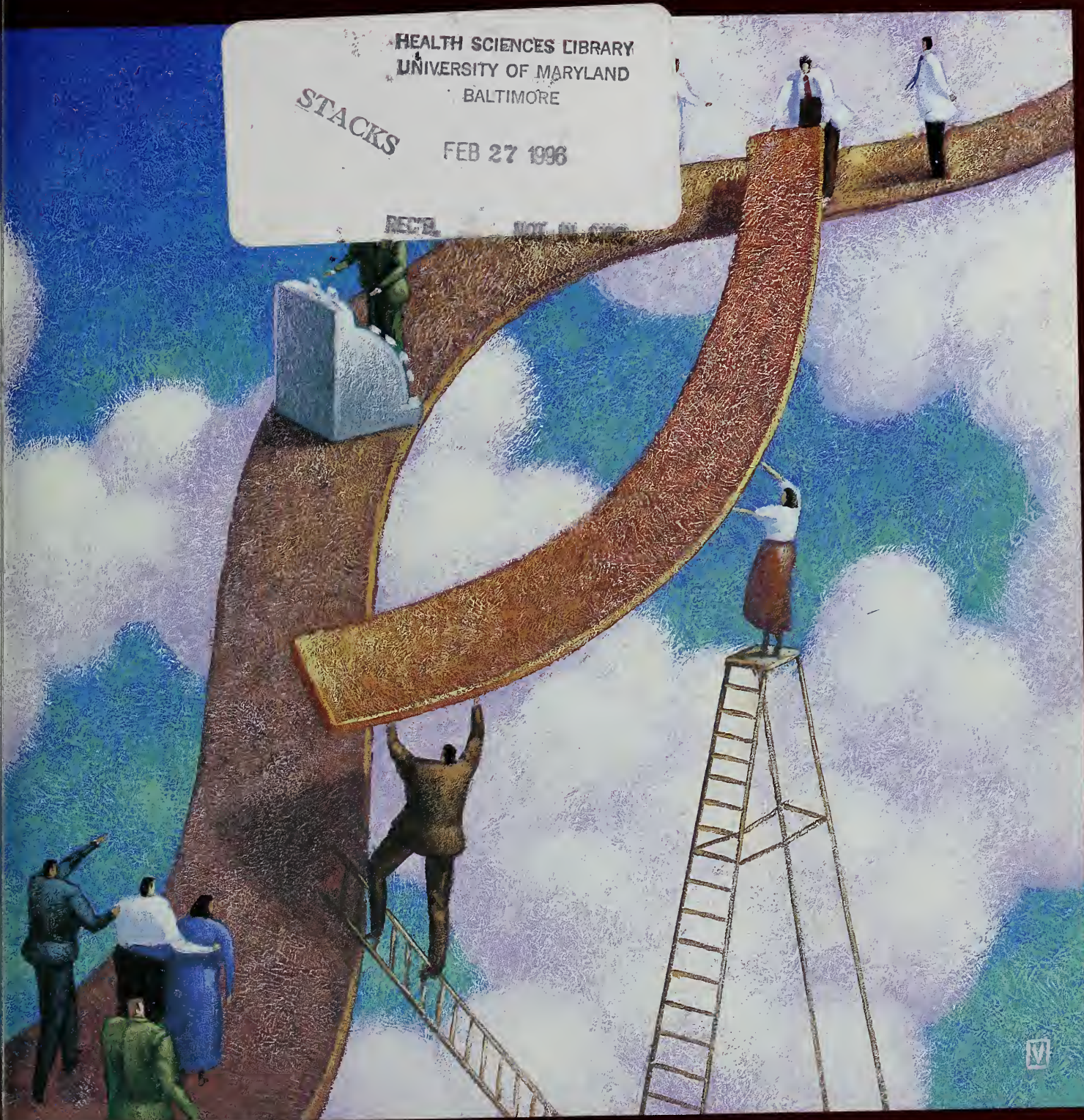
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Special HIV/AIDS Issue Carries Strong Message

I would like to express appreciation for the fine issue of *Minnesota Medicine* with the focus on HIV/AIDS (November 1995). For someone who was an early "AIDS activist," I was chilled to recognize how much of what was said about the sociopolitical impact of this disease is the same as we were saying in the early '80s. If anything will help make progress, it's the kind of focus that your magazine placed on this important health issue.

Thanks.

Morris Floyd
Vice President
Professional Services Group
Allina Health System
Minneapolis, Minnesota

Thumbs Up for the 'Stop the Media Violence' Campaign

The Adult Education Board at the Colonial Church of Edina would like to applaud and support your campaign to stop the media violence. Your brochure, "10 Tips for Parents to Stop the Media Violence," is a thought-provoking and useful piece, presenting concrete suggestions for all parents to consider.

We must all work to change a system that glorifies inappropriate, abusive, and illegal behaviors. Your leadership in this most important effort is gratefully acknowledged.

Jean C. Jacobs
on behalf of the
Adult Education Board
Colonial Church of Edina
Edina, Minnesota

Minneapolis Schools Join Effort to Stop the Media Violence

I am writing to thank the Minnesota Medical Association for the excellent brochures and posters you have made available through your campaign to stop the media violence and its modeling influence on the behavior of impressionable children and adults. Helping parents become more aware of what they can do to limit the appearance and influence of modeled violence in the media is very important to making our communities, including our schools, safer.

With your generous support, I have distributed your posters to staff who now display them in four schools and one mental health clinic. Administrators and parent liaison staff have made your brochures available to parents in elementary school lobbies and at parent conferences. After the positive responses your materials have received, and with your continued support, I will now be making more of your posters and brochures available through colleagues who serve as psychologists to most of the more than 75 schools in the Minneapolis Public School District.

Thank you again for your help in our mutual effort to make our communities safer and healthier places for children to develop and learn.

David Hazenson
School Psychologist
Minneapolis Public Schools

Telemedicine or Telemarketing?

The *Minnesota Medicine* article on telemedicine (March 1995) was indeed interesting. However, it

raises the issue of whether the subject really is telemedicine or telemarketing. Certainly, there is substantial promise in the electronic linkage of remote components of the health care delivery system. Yet, given the very high initial costs and the significant monthly support costs associated with this as yet unproven technology, it may be worthwhile to restrict the evolution of telemedicine to cooperative programs that amortize the start-up costs over a larger base and avoid costly duplication.

An abundance of outreach activities are being carried out by all tertiary care hospitals in Minnesota, in contrast to the dearth of outreach seen in southern, rural states, where many of the telemedicine initiatives have taken place. Perhaps it would be worthwhile to concentrate the initial telemedicine efforts on improved access to continuing medical education, timely transfer of medical information using nonpostal means, and enhanced critical care monitoring by larger centers on behalf of smaller centers, where patient volumes may not be high enough to maintain optimal skills.

In Minnesota's "managed competition" scenario, we conceivably could see not only Mayo, Allina, and the University of Minnesota with individual telemedicine networks, but also the Blue Cross network, the Fairview network, the Duluth Clinic network, and the Fargo Clinic network. It is far from clear that our health care system requires so much freedom of choice on the dial. A number of years ago, several Minnesota health care

providers felt that both helicopters and mobile catheterization laboratories improved access and, therefore, improved the health status of the communities they served. So far, little data have appeared to substantiate these opinions, yet millions of dollars have been spent staffing and equipping these programs.

While there is no progress without movement, movement and progress are not synonymous. Autonomous telemedicine programs should be merged into a single, public utility-model electronic medical data highway.

Name withheld on author's request

Ethical Dilemmas

I am working on a book about medical ethics and would like to enlist the help of other physicians to answer this question: Have you ever faced an ethical dilemma, and if so, how did you resolve it?

I am interested in all aspects of medical ethics—human experimentation; ethics of reproductive technology; abortion; medical treatment of the uninsured and poor; malpractice; physician-assisted suicide; the right-to-die (why some doctors do not honor living wills); genetic counseling; genetic manipulation; euthanasia; kidney, lung, and heart transplantation; use of fetal tissue; or any other situation concerning an ethical dilemma.

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For Good or Evil, Doctors Are Tempted by Direct Contracting

Charles R. Meyer, M.D.

In the beginning, there were doctors and patients. Doctors treated patients and submitted bills, and patients paid them. For a while, most patients and most doctors saw that it was good.

Then insurance companies were created. Now doctors treated patients and submitted bills to their insurance companies, who paid the doctors because the patients had been paying the insurance companies regularly. Still, most doctors, most patients, and, verily, all insurance companies saw that it was good.

Then HMOs, PPOs, IPAs, and ISNs were created. Now, doctors treated patients, following suggestions from these acronymic creatures, who then paid the doctors part of what they charged. Fewer doctors, most patients, and, verily, all acronymic creatures saw that it was good.

Then many doctors were swallowed by the acronymic creatures, creating new, more complex forms of life, which were vertically integrated. What doctors remained outside the belly of these newly formed creatures continued to treat patients and submit bills, but increasingly, the vertically integrated creatures, satiated by their previous meals, ignored these doctors. Now few doctors, fewer patients, and, verily, all the vertically integrated creatures saw that it was good.

In the beginning, it was simpler. And doctors' yen for the "good old days" is a desire to return to payment systems and patient relationships that were truly easier to fathom and abide. Perhaps nowhere in the country is the Genesis story further along than in Minnesota. We have seen more health care delivery animals than Noah ever dreamed of. Minnesota docs have a right to feel flooded.

Some physicians see direct con-



"We have seen more health care delivery animals than Noah ever dreamed of."

tracting, featured in this month's *Minnesota Medicine*, as possible salvation from the deluge. Direct contracting is an agreement directly between employers and providers. In Minnesota, it was introduced by the 1992 Business (now *Buyers*) Health Care Action Group. Yet, as BHCAG Executive Director Steve Wetzell says in his article (page 15), this first attempt at direct contracting triggered an unintentional consolidation of Minnesota's health care delivery system. Wetzell details BHCAG's new initiative, which the group hopes will more closely link quality providers with employers.

Lest physicians think the realization of BHCAG's proposal will land us back in the Garden of Eden, read Allan Baumgarten and Kathleen Vanderwall's summary of direct contracting (page 10) and Carol O'Brien's analysis of the legal ramifications (page 21). There is more than one snake in this paradise. Here are a few:

- Risk: Under direct contracting, providers assume at least part of the financial risk of delivering health care.

The key unanswered questions are financial and regulatory—will providers be able to stay afloat financially while delivering quality care, and how will the government deal with these new beasts of risk?

- The other creatures are still alive: The insurance companies and HMOs will not graciously bow out of this arrangement. Likely, even the most direct of contracts between providers and employers will utilize some services from third-party payers.

- "Providers" are not the old-time doctor: Small, unallied provider groups are not part of this grand scheme. The demands of risk assumption and quality and outcome measurement eliminate the small fry from the chosen. Even the term "provider" has blurred with Allina's and HealthPartners' vertical integration.

- BHCAG's heaven may be hard to reach: Even if divine intervention produces the system described by Wetzell, with employers and providers talking in the same tongues, will consumers (patients) learn the new language of outcomes and quality measurements and choose accordingly? Will they accept a system that is bound to restrict the inalienable right unknown to our Founding Fathers, choice of provider?

So creation is not finished. What emerges from the big bang that has been health care in Minnesota in the '80s and '90s will not be a return to a one doctor/one patient fiscal relationship. More in the spirit of Darwinism than creationism, the hydra-like beasts of integration will adapt to the demands of payers and patients and will survive in some form. Physicians, too, will have to adapt and seek new ways to live in tomorrow's cosmos. Otherwise, they will be left in the garden, munching apples.

MM

IN THE PUBLIC INTEREST

By Joseph Moriarity

Minnesota
Attorney General
Skip Humphrey
joins the MMA in
combating social
ills that threaten
the public health.

Add champion of the public health to Minnesota Attorney General Hubert (Skip) Humphrey's already impressive accomplishments as an anti-crime activist, watchdog for taxpayers' interests, children's

advocate, environmental leader, and consumer protector. First elected attorney general in 1982, Humphrey was re-elected in 1986, 1990, and 1994, a demonstration of the high regard in which he's held in Minnesota. His work with various community organizations on public health issues includes efforts to reduce violence and drug use in Minnesota, strong action to curb teen smoking, and a one-of-a-kind lawsuit against the tobacco industry—all efforts the Minnesota Medical Association supports.

Champion of the Public Health

Reducing violence

An open and gregarious man, Humphrey approaches his work with enthusiasm and intensity. "Let's talk about violence first," he says, "because its reduction and elimination is my No. 1 priority." Why? As violence increases, the system gets more overloaded; more police are needed, and more people are incarcerated, requiring more prisons—all at tremendous cost to the taxpayer, he says. "But violence is no longer just a legal problem. As the MMA is helping all Minnesotans realize, it has become an enormous public health problem, too."

Humphrey is well versed in the public health ramifications of violence. He knows the statistics: gun violence alone kills 40,000 people and harms another 240,000 each year in the United States. Its direct and indirect costs exceed \$14 billion annually, 80 percent of which is paid for by taxpayers.

"These economic costs are alarmingly high—and growing. Given our national priority to contain medical costs at a level that's still affordable for everyone, we *have* to reduce the violence in our society. But the problem goes beyond economics,"



Minnesota Attorney General Hubert H. Humphrey III.

says Humphrey. "When you look at the personal side of violence, its disastrous effects are clear—victims are physically, psychologically, and emotionally devastated. Violence breaks down not just individuals, but families, thus damaging or destroying the very relationship that's absolutely necessary to maintain a healthy, civil society."

Doctors know violence is a disease that can't be isolated in prisons or in certain neighborhoods. If it's not stopped, it will infect every one of us, says Humphrey. But the attorney general's office doesn't have the jurisdiction to deal directly with this problem. It needs allies to provide the driving force for the societal change in attitudes necessary to reduce and prevent violence.

"The MMA's perspective—and its willingness to speak out loudly—has had a tremendous impact on

our office, on the public, and, frankly, in the Legislature, too," he says. "Doctors are highly respected in this society, and many people see their family doctor as a personal adviser—unlike lawyers, police officers, prosecutors, public defenders, or other professionals. The MMA provides an avenue of communication to the public that our office could never achieve."

Together, the MMA and the attorney general's office are attacking the "germs of violence in our culture," as Humphrey puts it, and a primary focus is media violence. By the time most young people graduate from high school, they have witnessed more than 200,000 acts of media violence. Research by the National Institute of Mental Health and other organizations shows that children exposed to high levels of media violence are much more likely to be aggressive, to exhibit violent behavior, and to see violence as an effective way to resolve conflicts. Addressing the problem, however, is difficult because

the Constitution's guarantee of free speech limits legal action.

Rather than trying to legislate program content, a working group that includes the Minnesota Center for Corporate Responsibility, the Minnesota Medical Association, Humphrey's office, and David Walsh, Ph.D., author of "Selling Out America's Children," is focusing on corporate responsibility to reduce media violence. "We're working to establish voluntary standards for the type of programming corporations support through their advertising," says Humphrey. "Having the MMA explain the impact of media violence to corporations has a huge positive impact. Doctors see the effects of domestic violence in their offices and the effects of gun violence in their emer-

HUMPHREY continued on page 55

At the Summit

Minnesota Youth Lobby for Gun Safety

A diverse group of nearly 200 students—from honor students to gang members—testified before the state Legislature last month on the merits of MMA's safe firearms storage bill.

When 20-year-old Zeke Terhark stood before lawmakers at the state Capitol January 17, he wore his flannel shirt, his black jeans, and his long hair loose. He wasn't concerned with what the legislators thought of his attire. He only cared that they heard what he had to say: Something needs to be done about a society so dangerous that most kids know someone killed by violence and most have easy access to guns.

Terhark is one of 197 students from across the state who testified as part of the 1996 Minnesota Youth Summit on Reducing Gun Violence. The day after the state legislative session officially began, students from grades eight through 12 told lawmakers their thoughts about Minnesota Medical Association-sponsored legislation that would require stored guns to be unloaded and locked away from ammunition in homes where children under age 18 are present.

In sometimes emotional testimony, participants told of friends and family members lost to gun violence and about their own fears. The stories made

it clear that guns are part of many kids' everyday lives. While a majority of students supported the MMA's proposal, others expressed doubts about its enforcement. Some argued that the law would be no deterrent to kids "packing" guns on the street, and still others said they need their guns for self-protection.

The second annual Youth Summit was sponsored by the Minnesota Medical Association, the office of Attorney General Hubert H. Humphrey III, and the University of Minnesota's Minnesota Center for Community Legal Education at the Center for 4-H Youth Development.

Humphrey has a history of commitment to youth. Three years ago, when the state looked at revising state laws concerning juveniles, he created a youth task force to examine recommended changes and testify before legislators. Jennifer Bloom, director of the Minnesota Center for Community Legal Education, remembered this when her de-



ILLUSTRATION BY JAMES O'BRIEN

BY KRISTI BELCAMINO

partment received funding from the U.S. Department of Justice's "Youth for Justice" program to hold a Youth Summit on violence prevention. She asked the attorney general's office to participate.

"[Humphrey] reflected a commitment to have kids involved in legislation that affects kids," says Bloom. "We knew we wanted our summit to involve kids in actual lawmaking—not just watching what was going on or pretending in class, but to have them involved in significant bills that impact kids."

Last year, 150 students gave suggestions and pointed out potential problems in the Safe Schools Bill, which later passed. This year, after hearing about the MMA's proposed bill, Bloom decided to focus the summit on the safe firearms storage legislation. "When you consider the Minneapolis homicide statistics this year, this is a perfect issue, [especially given] Justice Department statistics concerning the use of guns by juveniles in crimes. Kids are killing kids with guns. It's the fastest growing area of crime right now."

In fact, firearms are the second leading cause of injury and death in the United States and are expected to hit No. 1 by 2003, according to a June 14, 1995, article in the *Journal of the American Medical Association*.¹ In an editorial in the same issue, John P. May, M.D., reports that more teenagers die from firearm injuries than all natural causes combined. Homes with firearms are more likely to experience homicides and suicides than homes without firearms, he says.² Additionally, the U.S. Department of Justice reports that nearly half of all homes in the United States contain at least one firearm.

Recognizing the urgency of the firearm problem, Marshall physician Theodore L. Fritsche, M.D., brought forth a resolution at the Minnesota Medical Association's annual meeting last September mandating the use of trigger locks. The resolution passed, even though it was not on the original agenda, and it evolved into the current safe firearms storage bill.

Mark Vukelich, MMA communications director, predicts this legislation would reduce the likelihood of a gun being fired by a despondent teenager considering suicide or an inquisitive child or teen. "Young people are getting a hold of guns while their parents are away. Maybe they have other kids over and maybe drinking is involved, but someone pulls out a gun, plays with it, and it goes off," says Vukelich.

The MMA also believes keeping guns locked may serve as a built-in cooling down period in domestic

disputes. "If someone has to go get the key, they might think twice before using a gun. This may reduce fit-of-rage shootings," says Vukelich.

Zeke Terhark, a senior at the Dakota County Alternative Learning center, participated in last year's summit and supports the idea that guns be locked. "I believe that if [people are] going to have a gun in a home with children, it should be locked up. If a little kid gets a hold of a gun, something is going to happen."

Students interested in the summit signed up in December, giving them a little over a month to prepare. Participants from 50 schools were directed in their research by one or two of their teachers. Bloom also sent them packets of information, including previous court decisions, magazine articles, and statistics. They were encouraged to meet with community members, such as police officers, gun shop owners, and doctors who treat gunshot wounds.

There are no criteria for participation in the summit; students are selected on a first-come, first-served basis. This year's summit involved a record number of participants, including students of all types—honor students, gang members, and rural, suburban, and inner-city students—because Bloom believes it is essential to represent a broad cross section of youth. "On the issue of gun violence, it's insane to include only students who have never found themselves victims or perpetrators," she says.

On the day of the summit, the students prepared by meeting in small groups at the Capitol and by spending time with people familiar with the law. They met among themselves to review their material, share their research, and brainstorm for new ideas in a mock hearing. Then, in the afternoon, the students met with the authors of the safe firearms storage bill and other interested legislators. They testified on whether they believe the legislation would be beneficial, identified possible problems, and offered suggestions.

"I hope the students and I made a difference in getting this into law," says Terhark. "If there's a gun in the house, I want it to be locked." MM

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REFERENCES

1. Kizer KW, Vassar MJ, Harry RL, Layton KD. Hospitalization charges, costs and income for firearm-related injuries at a University Trauma Center. *JAMA* 1995;273(22):1768.
2. Taking aim at handgun violence. *JAMA* 1995;273(22):1739.

CONSTRUCTING *the* DIRECT DEAL

A regulatory Catch-22?

*Direct contracting
between providers
and employers
may increase
competition, but
will the advan-
tages dwindle
under regulation?*

When is a network of health care providers not just a network? When state regulators decide that it quacks and waddles like an insurance company and is, therefore, an insurance company.

This riddle illustrates the issues state regulators face as market developments transform the way health care is purchased and provided in Minnesota and the rest of the country.

Physicians and hospitals have formed a variety of organizations to be more competitive in their respective marketplaces. While these networks may be similar in many ways, each is unique. For example, these integrated delivery systems may be formed by full mergers of providers with each other or with health plans, or by contracts that unite the parties for certain purposes while maintaining their separate ownership. They are known by different names—clinics without walls, physician-hospital organizations, integrated service networks, and provider cooperatives, among others. The organizations may serve a variety of functions, and the extent of their organizational and financial integration varies.

They have formed for a variety of reasons:

- the desire of physicians and hospitals to move higher up on the health care "food chain" and to regain some of the economic power they have lost to health maintenance organizations (HMOs) in the past 20 years;
- the interest of purchasers in contracting directly with providers who can dem-

by ALLAN BAUMGARTEN, J.D., M.A.,
AND KATHLEEN VANDERWALL, M.S.





ILLUSTRATION BY PAUL VISMARA

onstrate that they deliver cost-effective care; and

- as a response to state initiatives intended to stimulate local markets to help attain state goals of expanding access to high-quality care while containing costs.

These new organizations seek to contract with HMOs and health plans, providing them with prepackaged provider networks. But they also have targeted self-funded employer groups or purchasing alliances, hoping to contract directly with those employers and largely bypass the health plan middleman.

JUST WHAT IS DIRECT CONTRACTING?

Direct contracting refers to a contract for health care services made between an employer or group of employers and health care providers. This is in contrast to the typical situation where employers purchase health care coverage from an insurer or from a health plan such as an HMO or Blue Cross/Blue Shield.

Direct contracting is not new in Minnesota. For example, HealthEast Care reported that in 1994 it enrolled almost 44,000 patients through direct contracts with employers in its service area. Similarly, HealthSystem Minnesota, the parent of Park Nicollet Clinic and Methodist Hospital, offers a number of directly contracted arrangements to employers. In one case, it is a partner in a joint venture (First Integrated Holding) with Blue Cross and Blue Shield of Minnesota. In the Rochester area, the Mayo Clinic contracts directly with employers. In each case, these health systems operate much like preferred provider organizations and do not accept insurance risk. The risk remains with the self-funded employers contracting with the network.

Direct contracting has received much attention in the last year for two reasons. First, provider groups, particularly the Minnesota Hospital Association (now the Minnesota Hospital and Health-care Partnership), have gone to the Legislature seeking to lower or remove regulatory barriers to direct contracting. They have gained some small victories, which we describe below. Second, the Buyers Health Care Action Group (BHCAG), a Twin Cities-based buying coalition consisting of large employer groups, announced last summer that its members intended to contract directly with numerous provider care systems—a significant change in purchasing strategy for those companies.

Three years ago, the BHCAG companies sought proposals for a new way to buy self-funded health

care for their employees. They wanted to deal with one large integrated health care system that covered the entire Twin Cities area and shared the employers' goals of improving quality and aligning financial incentives for providers, purchasers, and patients alike. They eventually chose a consortium consisting of the HealthPartners HMOs, Park Nicollet, and Mayo Clinic.

To a large extent, the mergers and joint ventures between health plans and provider organizations that followed in 1993 and 1994 were based on an expectation that purchasers would want to buy health care from large systems. Imagine the surprise when BHCAG announced in July 1995 its new purchasing strategy—to contract directly with *small* provider care systems. (For a more detailed explanation of BHCAG's plans, see page 15.)

IF DIRECT CONTRACTING IS THE SOLUTION, WHAT IS THE PROBLEM?

What are the possible benefits of expanding the use of direct contracting?

- It may encourage competition. To the extent that purchasers are willing to negotiate contracts with smaller provider groups, more small groups will be able to compete. Provider groups will not need to have all health care services available within their organizations, and they may contract with HMOs or other groups for specialty and ancillary services.

- It may increase consumer choice, as well as provide more information about available options in health care services. With increased competition among providers, purchasers may have more leverage to require providers to furnish information about quality. The information will allow consumers or group purchasers to shop for health coverage based on quality, as well as cost, enhancing consumers' influence in the health care market.

- It may increase provider accountability and improve incentives for providers to offer cost-effective, high-quality care.

When health care is purchased from health care plans with large, overlapping provider networks, individual providers may not be held accountable for the quality of care they provide. With direct contracting, providers would be competing in the health care market and would need to be accountable for both cost and quality of care.

Some physicians welcome direct contracting as an opportunity to have broader access to patients and to have more say on the terms. In the current marketplace, HMOs and other health plans exert

significant control over the flow of patients to physicians.

"Physicians are cautiously interested in the opportunity presented by direct contracting," says Tim Crimmins, M.D., an emergency medicine specialist at Hennepin County Medical Center and board chair of the Minnesota Medical Association. "They see it as a way of maintaining flexibility, clinical autonomy, and competition in the face of trends toward a market in which a few large systems employ all the physicians. Yet they are wary of all the provider-based organizations that have come and gone." Many physicians still hold bitter memories of how doctors lost control of Physicians Health Plan, the HMO established 20 years ago by the Hennepin County Medical Society (now Hennepin Medical Society).

The Minnesota Hospital and Healthcare Partnership (MHHP), formed by the merger of the Minnesota Hospital Association and the Metropolitan Healthcare Council, has been among the most enthusiastic backers of direct contracting. MHA and MHC supported bills in 1994 and 1995 that created new means for providers to contract with health plans and employers.

In 1994, Minnesota dusted off its agricultural cooperative law to enable the creation of health care co-operatives. Co-ops may consist of individual providers, clinics, and/or hospitals organized for the purpose of marketing and delivering health care services to purchasers. Payments to cooperatives by purchasers are required to be substantially capitated or to involve similar risk-sharing arrangements. Provider co-ops are not licensed by the state.

The issue of risk-sharing is key. Under antitrust law, a group of independently owned providers that comes together to contract with health plans

or purchasers must accept significant financial risk. Otherwise, the arrangement is viewed with suspicion as a pretext to come together for the illegal purpose of fixing prices.

The hospitals' hopes for more flexibility were short-lived. A few months after the end of the 1994 session, the commissioners of health and commerce issued a joint statement declaring that a provider cooperative would be deemed an *insurance company* if it entered into a contract with a purchaser that involved risk-sharing by the co-op. As such, the cooperative would need an insurance license to transact business in Minnesota and would be subject to state insurance regulations for solvency, consumer protection, and so on.

Sharon Ericson, project director of the Minnesota Rural Health Cooperative in Willmar, suggests that insurance regulators may be missing a key reality of rural health care. "Providers—especially hospitals—are crucial in rural areas, providing a hub for services. Without them, we wouldn't have physicians, home health care, home-delivered meals for seniors."

In a sense, these providers are already accepting risk. "Insurance is expensive, and many employers can't afford it. Rural hospitals and physicians are already accepting risk because they provide services anyway, whether they get paid or not. So why is it different if an

employer contracts with providers?" Ericson asks. Providers see direct contracting as a means of



DIRECT CONTRACTING cont. on page 58

Look for this seal




The 21st Century will usher in significant changes in the medical profession. To help physicians meet these challenges, the MMA and HMS founded Minnesota Medical Business Resources (MMBR—pronounced MeMBer), a physician-owned corporation, dedicated to uncovering and meeting physicians' personal and professional needs.

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CONSUMER CLOUT

The Buyers Health Care Action Group wants informed patients to drive the health care market.

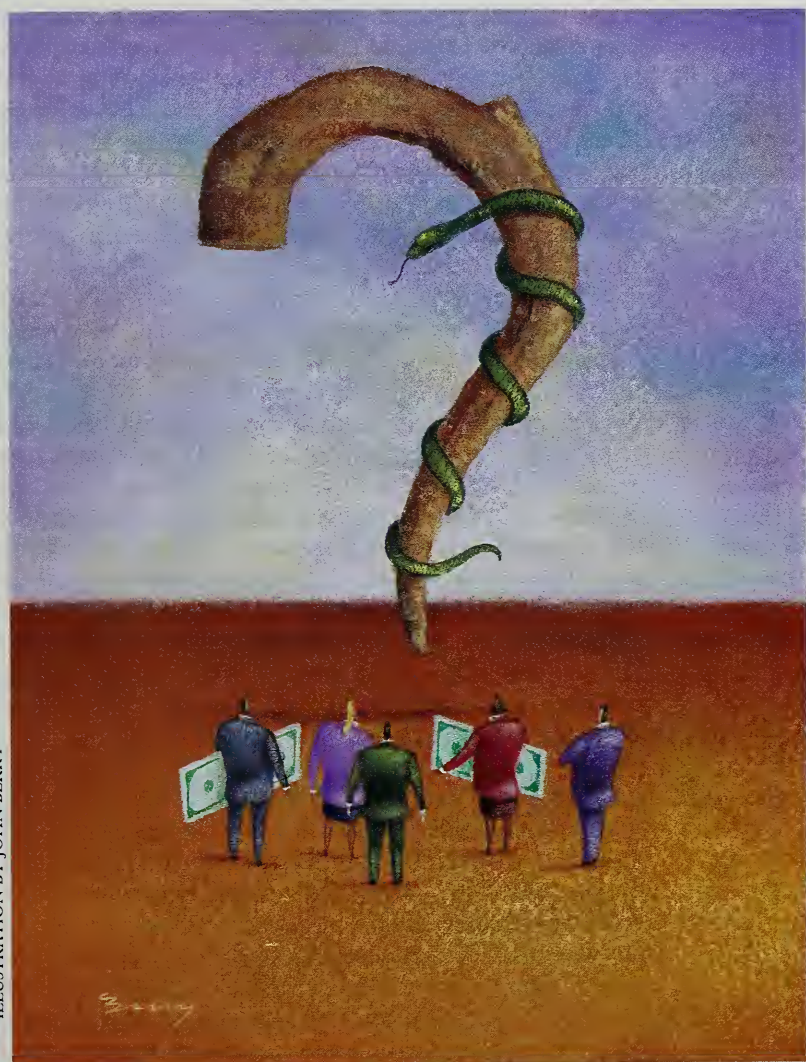


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by STEVE
WETZELL

tions throughout Minnesota, eastern North and South Dakota, and western Wisconsin. Through a series of steps defined in this RFP, BHCAG will select and contract with a number of care systems (integrated teams of providers) by the middle of 1996. The new

American industry faces increasingly rapid change and tougher competitive demands. Health care is no exception, and a group of major Minnesota-based employers has challenged the health care industry to provide purchasers and consumers with improved value. The 24 member employers of the Buyers Health Care Action Group (BHCAG) have been a powerful force in local health care purchasing and reform for several years. This innovative group of purchasers is moving ahead with an aggressive new plan to provide employees with more choices and better health care for their dollar.

Late in December, BHCAG distributed Requests for Proposals to more than 275 provider organiza-

plan will be implemented and care system contracts will become effective January 1, 1997.

ABOUT BHCAG

The Buyers Health Care Action Group is a coalition of 24 self-insured employers (see page 18 for a list) representing 400,000 employees, retirees, and dependents in the four-state area mentioned above. Its mission is to stimulate reform of the health care system by building a program founded on four principles: increased quality, increased provider competition, increased consumer knowledge and responsibility for health care decision-making, and enhanced efficiency of health care delivery.

Since 1993, BHCAG members have offered employees a self-insured health plan, called Choice Plus, that embodies these principles. Choice Plus is administered by HealthPartners with claims paid by its subcontractor, Aetna. Some companies offer Choice Plus as their exclusive health benefits program. Others offer employees a choice between Choice Plus and one or more other managed care or indemnity plans.

Choice Plus is neither an HMO nor a traditional insurance plan. It is a self-insured plan with out-of-network coverage, structured around a large network of primary care physicians, hospitals, and other health care providers. Services provided within the network are covered at the highest level of benefits possible in the plan, while out-of-network services are covered at lower levels, unless a member is referred by a network provider.

About a year ago, BHCAG announced the next step in the evolution of its purchasing strategy, an attempt to offer consumers a choice of a number of alternative "care systems," which would compete for market share based on the relative quality, cost, and service they provide. BHCAG is calling this approach the Consumer Choice Model.

CONSUMER CHOICE MODEL

BHCAG is changing its buying model to create a market more directly driven by consumers and provider responses to consumer needs. Accordingly, under the new model, consumers will be able to choose among care systems based on the systems' costs, who their providers are, and their performance in areas of quality and customer service. The new model introduces three key changes: direct contracting with multiple care systems,



better consumer information, and varied premiums based on care systems' claim targets.

Care systems

Beginning in 1997, the Buyers Health Care Action Group and/or its administrator will contract directly with mul-

tiple care systems—primary care-centered health systems and their affiliated specialty physicians, hospitals, and allied professionals. Employees enrolled in Choice Plus will each be required to choose a care system. An employee might choose a care system based on a particular clinic in the system, but the pricing and performance information available will describe the care system as a whole.

Organized by physicians, PHOs, or any other entity, a care system will provide (or contract for) the full continuum of medically necessary services for an enrolled population. Any given primary care provider will participate in only one care system within Choice Plus. In preparation for the new model, BHCAG expects that physicians currently participating in Choice Plus will be selecting care systems with which to affiliate. BHCAG will also add new Twin Cities metro-area care systems consisting of providers not currently part of Choice Plus. An undetermined number of non-metro care systems may also be added for 1997, and some others in 1998. As a result, employees and dependents who enroll in Choice Plus will have a larger choice of providers than they have had in the past.

Improved consumer information

To help consumers select a care system, each year BHCAG will provide all employees in the Choice Plus service areas with information comparing the attributes and performance of all care systems that are part of Choice Plus.* The information will compare the cost of care systems (based on bid claim targets) and performance along a number of quality and service dimensions. Consumers will have access to three types of information:

*BHCAG will rely heavily on patient-derived measures to develop information consumers can use this year to select their care system for 1997. Not all types of information will be immediately available to Choice Plus members in 1997.

- descriptive information on the care system and on the particular clinics within each care system (including location, hours, and on-site services available), information on individual physicians (including training, certification, statements of philosophy, and languages spoken), and information on specialist referral and hospital relationships;

- comparisons of quality at the care system level, including both clinical measures of technical quality and patient-reported measures of care quality; and

- comparisons of customer service and satisfaction among care systems. These will be the results of patient surveys addressing such things as accessibility, ease of seeing the doctor of one's choice, waiting times for appointments and in the waiting rooms, and staff courtesy.

The consumer information will be presented on touch-screen kiosks at member companies, in an abbreviated paper version, and may be available through employers' local area networks, the Internet, and on diskette.

Variable premiums

Employees choosing to enroll in Choice Plus will pay different premiums depending on which care system they select, while benefit levels will be identical across all care systems. The premium differentials will be based on the actual claim targets bid by the various care systems. Employees who select a less costly system will pay less. (Family members may choose different care systems, but the family as a whole will pay according to the highest-cost system chosen by any one family member.)

It is possible that not all BHCAG employers will implement the premium differentials in 1997; some may wait until 1998. All employers will offer Choice Plus with its expanded set of care systems in 1997, and all care systems will be paid according to a standard fee-for-service payment system.

For the first time in this health care market, the relative costs of providers and their affiliated care systems will be visible to employees and will affect their out-of-pocket premiums. The visibility of cost differences among care systems is key to BHCAG's new buying model. Under the new model, BHCAG expects the market will be driven by consumer values, including the level of quality or service for which consumers are willing to pay. Care systems will compete for individual consumer mar-

ket share based on quality, consumer satisfaction, and risk-adjusted cost for a standard set of covered services.

OBJECTIVES

If executed as planned, the new Consumer Choice Model will meet these BHCAG objectives:

- align incentives for consumers, providers, and BHCAG member employers;
- make the consumer the most important customer in the health care market;
- empower employees, retirees, and their families to choose care systems based on what is important to them;
- create more choices and long-term stability for consumers;
- create a self-insured health plan that will support continuous quality improvement by rewarding high-quality, high-service, cost-effective care systems financially and with increased market share;
- create provider accountability for quality, service, and cost;
- strengthen providers' sense of ownership and advocacy for their care systems;
- stimulate innovation and creativity in the development and management of care systems;
- create a health care market in which care systems collaborate, when appropriate, to optimize quality, service, and efficiency;
- limit the intermediary roles of employers and health plans to specific, value-added services, such as care system performance measurement, member enrollment, and claims adjudication; and
- create competition among potential vendors of value-added services to support care systems.

OPERATIONAL FEATURES

We believe it is difficult to disagree with the general principles and goals of this purchasing model. However, like most innovative ideas, the devil is in the details. Just how do BHCAG member employers plan to make the model work?

Provider participation

Primary care physicians may only participate in one care system for purposes of BHCAG's Choice Plus plan.

BHCAG defines family practitioners, pediatricians, and internists as primary care physicians, although a care system may also define ob/gyns as primary care provid-

"BHCAG is changing its buying model to create a market more directly driven by consumers and provider responses to consumer needs."

ers. (Primary care physicians may submit RFP responses with more than one care system but must select a single care system before June 1, 1996.) Specialists, allied professionals, and hospitals may participate in multiple care systems. Provider payment will be designed to reward effectiveness and efficiency.

Annual enrollment

Choice Plus members will choose annually from an array of care systems (rather than health plans). BHCAG will provide all employees with comparative information on service quality, clinical quality, and cost at the care system level to help employees select a care system. Generally, Choice Plus members will remain with a care system for a full plan year. However, enrollees will be able to switch during the year to other care systems of equal or lower cost. (Choice Plus enrollees currently have the option to change primary care providers during the year. However, only 2 percent do so for reasons other than location. We believe few people will change care systems during the year even though they have that option.)

Standard benefit design(s)

The same BHCAG benefit design or designs will apply equally to all care systems. All BHCAG benefit plans will provide coverage for the same medically necessary services. By 1997 or 1998, two to three different levels of benefits may be available (with varying copays). BHCAG employers would have the option of offering one or more of the BHCAG plan designs to their employees.

Price competition

BHCAG employers will remain self-insured. Care systems will submit target per member per month rates for a standard population and set of covered services. Differ-

BHCAG MEMBER EMPLOYERS

These Minnesota-based employers make up the Buyers Health Care Action Group:

- American Express Financial Corp.
- Bemis Company
- Cargill
- Carlson Companies
- CENEX
- Ceridian Corp.
- Dayton Hudson Corp.
- First Bank System
- General Mills
- Honeywell
- Jostens
- Land O'Lakes
- Minnegasco
- Minn. Dept. of Employee Relations
- Minnesota Mutual
- Norwest Corp.
- Northern States Power Co.
- Target Stores
- Pillsbury
- Rosemount
- Rosemount Aerospace
- SuperValu
- Tennant
- 3M

ences in care system target rates will be reflected directly in premiums paid by plan enrollees. For example, if the employer contributes \$100 per month and the employee chooses a provider whose claim target is \$110, the employee pays \$10 per month. Each BHCAG employer will be responsible for whatever shortfalls or surpluses arise when the actual fee-for-service cost of care for their enrollees is different from the BHCAG employer's premium contribution plus the members' premiums.

BHCAG will make risk adjustments to care systems' claim targets to account for the illness differences between the care systems' populations, and care systems' fee schedules will be prospectively adjusted up or down based on how they perform relative to their risk-adjusted claim target. The goal is to bring actual experience in line with the claim target. For a standard patient population, if the care system's claims are lower than the

claim target, the fee schedule conversion factor will be higher in the next quarter. If the claims are higher than the target, the fee schedule will be lower. There will be no retrospective recovery or payment of money.

Administration

The Business Health Care Action Group has retained HealthPartners and its subcontractor, Aetna, to provide such administrative services as enrollment, claims payment, member services, and certain plan-wide integration services through the 1997 plan year. Standard care system contracts will be developed and held by BHCAG, acting as agent for each BHCAG employer, and/or by BHCAG's administrator using a standard BHCAG contract.

THE BHCAG MODEL VS. ISNs AND HMOs

In many ways, the BHCAG approach is similar to the ISN/HMO concept, with several important distinctions. Philosophically, the new BHCAG model and the legislatively created ISNs are very similar. Both are designed to encourage competition between vertically integrated systems of care with the recognition that rural health care must be addressed as a cooperative effort between local providers and purchasers.

The most fundamental difference is that the BHCAG model carves out certain third-party administrator services from the ISN's role. In addition, because the BHCAG model is not state regulated, there are fewer rules for providers to comply with. Finally, because BHCAG member employers are self-insured and they hold the ultimate financial risk, providers are not required to have large capital reserves to enter and compete in the market.

In effect, the BHCAG model is a modified version of the state rules. It creates greater administrative econo-

mies of scale, eliminates a significant number of unnecessary regulatory requirements, gives consumers more choice and influence in the market, and allows far more provider competitors to enter the market on a level playing field.

WILL THE MODEL WORK?

Will BHCAG's new model result in more consumer choice, increased competition, and improved health care value? Will it empower providers to define their own networks and approaches to patient care? Only time will tell. Meanwhile, a variety of other models will also continue to operate in the market. No one knows the best way to make use of our limited health care resources, but the 24 member employers of BHCAG believe their new plan has the potential to create a more rational and consumer-friendly market. MM

Steve Wetzell is executive director of the Buyers Health Care Action Group.

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Direct Contracting: Potential Legal and Regulatory Barriers

The benefits and risks of direct contracting are difficult to sort out in the still-evolving legal climate.

Carol L. O'Brien, J.D.

Throughout the nation—and especially in Minnesota—physicians and other health care providers are becoming increasingly interested in direct contracting arrangements with employers. Direct contracting describes agreements between physicians or other provider groups and self-insured employers for the provision of health care services. These “direct” contracts can take many forms—from agreements between large corporations and highly integrated provider networks, to contracts between small, rural employers and local physician groups, to contracts between any type or size of employer and a group of physicians or a facility for carve-out or specialty services, such as cardiac care. Whatever the terms, many providers view direct contracting as a means to avoid or minimize the need for third-party insurance contracts or “middlemen.”

Direct contracts between physicians and employers sounds like the ideal—a return to the “good old days” before large insurance conglomerates began taking over health care. Indeed, direct contracting appears to be a promising strategy for physicians to cope with today’s highly competitive managed care market and for physicians to remain in charge of clinical decisions and costs. At the same time, direct contracting offers employers the possibility of cutting health benefit expenditures by reducing the sometimes inflated administrative costs

of insurance companies.

Despite these promises, however, direct contracting faces potential legal and regulatory barriers. Additionally, experts warn that while physicians may regain more control of clinical decisions under direct contracts, they may not necessarily reap higher compensation from employers than under current managed care programs. Finally, direct contracting may not prove workable in every market.

Conventional wisdom suggests that the time is ripe to consider direct contracting when a state or local market hits 20 percent managed care penetration. The key, experts say, is to be sure the employer market shows signs of managed care interest and growth, without the market being locked up. Nellie O’Gara, M.P.H., president of First Health Associates, Inc., in Chicago, believes the potential for direct contracting arrangements has not been tapped. She suggests physicians concentrate their efforts in small and medium-sized markets that offer few or no HMOs or other large managed care networks.

Such conventional wisdom may be challenged soon by the efforts of the Minnesota Buyers Health Care Action Group, a coalition of 24 large self-insured employers that intends to jump-start direct contracting in the Twin Cities—already dominated by just a few large health plan companies—by promoting competition among smaller integrated groups of providers. These “care systems” will

contract directly with BHCAG, competing for market share based on quality, cost, and service (see BHCAG article, page 15).

Along with marketing strategies, physician groups interested in direct contracting should be aware of a number of legal issues raised by these relationships. To date, the most significant are emerging ERISA and state insurance issues, as well as antitrust and liability concerns. While many of the issues related to direct contracting are uncertain, particularly whether capitated arrangements constitute the business of insurance, physicians should understand the benefits and the risks of direct contracting in the evolving legal climate and how to ensure that their contracts are drafted to avoid some potential pitfalls.

Capitation Contracts and the Business of Insurance

Traditionally, direct contracts between physicians and self-insured employers have been based on fee-for-service terms. The growth of capitation, however, has given rise to a new question: Do capitated direct contracts constitute the “business of insurance,” subject to state insurance regulation, HMO licensure, and other state legal requirements? When discussing this issue, physicians should be aware of the important legal differences between self-funded or self-insured employers and fully insured employers who purchase in-

Table

*State regulation of insurance risk assumed by provider groups contracting with self-insured employers**

• Partial insurance risk:	Regulators in 25 states and the District of Columbia said they have no affirmative policy to require licensure of a provider group when the transfer of risk is limited (e.g., up to 110 percent of an annual pre-determined budget).
• Full insurance risk:	Regulators in nine states and the District of Columbia reported no affirmative policy to require providers to become licensed as an HMO or to meet similar requirements if the provider group assumes full financial risk, such as capitation. The majority of state regulators indicated they would consider capitation contracts to be the business of insurance and would apply all state insurance and/or licensure requirements to such contracts.
• Downstream insurance risk:	Regulators in 26 states and the District of Columbia replied that state licensure is not necessary for provider groups that accept "downstream transfers" of insurance risk from a licensed health plan (e.g., the provider group contracts directly with the HMO/plan to provide services through or for the plan, but the health plan directly contracts with the employer).
• No insurance risk:	Regulators in 40 states and the District of Columbia reported that no state licensure or oversight is necessary when self-funded employers directly contract with providers on a fee-for-service or discounted fee-for-service basis.
• Minnesota reported	that it would not regulate contracts between self-funded employers and providers that involved fee-for-service terms or downstream risk. The state reported that it would regulate direct contracts based on capitation and partial risk, such as a pre-set budget.

*Group Health Association of America. PHOs and the assumption of insurance risk: a 50-state survey of regulators' attitudes toward PHO licensure. Washington, D.C.: Group Health Association of America, 10 July 1995.

insurance policies. This distinction often comes as a surprise to many physicians and patients because, in terms of plan operation, it is usually invisible.

Self-insured plans, which constitute about 60 percent of all U.S. employee benefit plans, differ from employer-purchased insurance policies in that self-insured plans cover employee health benefits through a discrete employer-sponsored trust fund maintained for that purpose. The differences are largely invisible because many self-funded plans con-

tract with a well-known insurance company to administer their claims. These plans, often called administrative services only, or ASO plans, look like fully insured plans because a large insurer like Blue Cross/Blue Shield pays and processes the claims. The risk for self-insured plan coverage, however, always lies with the employer, not the insurer. In contrast to insurers, which are subject to myriad state-based laws and regulations, self-funded plans are under the jurisdiction of a comprehensive federal law—the Employee Retirement

Income Security Act of 1974—that protects these plans from most state regulation.¹

All employer-sponsored employee benefit plans are subject to ERISA, which was enacted to provide a uniform federal scheme for large, multi-state employers operating employee pension and health benefit plans. Three provisions—the pre-emption, savings, and deemer clauses—are key to understanding how ERISA protects self-funded plans from state regulation and how it affects direct contracting.

The pre-emption clause states that ERISA requirements shall supersede any state laws related to an employee benefit plan.² The courts have interpreted ERISA's pre-emption clause expansively, holding that a wide variety of state laws, including managed care reforms, any-willing-provider laws, and mandated benefits laws, are pre-empted by ERISA, and, therefore, not applicable to self-insured employee benefit plans.

ERISA itself contains an exception to the sweeping pre-emption doctrine. Popularly known as the savings clause, the exception prohibits application of ERISA's pre-emption clause to any state law that regulates "the business of insurance, banking, or securities."³

This does not mean, however, that states may freely regulate self-insured employee benefit plans; under ERISA's deemer provision, an employee benefit plan shall not be "deemed" the business of insurance, banking, or securities simply because the plan offers benefits to employees. ERISA law is developing rapidly, and interpretation of these three clauses has led to substantial legal wrangling over defining what activities states can regulate with respect to self-funded plans.

In 1985, the U.S. Supreme Court, in a unanimous decision, enunciated the pivotal legal distinction between fully insured and self-insured plans under ERISA. In the case, *Metropolitan Life Insurance Co. v. Massachusetts*,⁴ the U.S. Supreme Court considered whether a self-funded plan was required to provide a state-mandated mental health benefit. The

court determined that when a plan was self-funded or self-insured, it was subject only to ERISA's federal requirements, which pre-empt any state laws attempting to regulate such a plan. Therefore, the plan was not required to provide the state-mandated mental health benefit. The Supreme Court did, however, draw a distinction between the benefits provided from the employer's self-funded trust fund and certain other benefits provided through discrete insurance policies. The court said that while the state could not directly regulate the self-funded employee benefit fund, it could regulate the terms and conditions of benefits provided under separate policies obtained from an insurer and held by the plan.

The *Metropolitan Life* decision created a divided regulatory system, leaving states and employee benefit plans to struggle with the issue of when states may exert some authority over self-insured plans. However, in legal battles concerning state control over particular aspects of self-insured plans, such as solvency standards, use of stop-loss insurance, and regulation of third-party administrators, the states generally have failed to convince the courts that their interests should outweigh ERISA pre-emption.*

Thus, under ERISA's flexible federal scheme, self-insured plans generally are free to contract directly with physician groups on a fee-for-service or retrospective payment basis without state regulatory interference. However, such plans and the physicians with whom they contract may face a state legal challenge if the contract involves a transfer of risk that could be perceived as insurance-type risk, including capitation contracts and withholds from the employer to the provider. In fact, these emerging state regulatory concerns chilled a burgeoning interest in direct contracting in August, when the National Association of Insurance Commissioners (NAIC) issued a bul-

letin urging all state insurance commissioners to scrutinize direct contracting activity. NAIC guidelines, still being drafted, currently recommend that state insurance regulators require provider groups that assume any form of risk to be regulated as insurers.

In reaching this conclusion, the NAIC warned: "Groups of health-

"Direct contracting
appears to be a
promising strategy for
physicians to cope
with today's highly
competitive managed
care market and to
remain in charge of
clinical decisions."

care providers may be entering into certain types of compensation, reimbursement, and risk-sharing arrangements that rise to the level of being the business of insurance without first obtaining a license or certificate of authority from state insurance regulators, in violation of state laws." The NAIC added that it would consider capitated contracts between providers and employers as insurance contracts subject to insurance and HMO licensure laws.

The level of insurance-type risk that provider groups contracting with self-insured employers may assume and the issue of whether state or federal (ERISA) regulatory authority should control these contracts remains unclear. The accompanying table (page 22) summarizes current state regulations compiled in a July 1995 study by the Group Health Association of America, the nation's leading HMO trade association.

Despite the chilling effect of last year's bulletin, the NAIC's position that capitation contracts constitute "insurance" remains an open legal

question. In *Oracare DPO v. Merin*,⁵ a federal court ruled that a state law attempting to bar a dental service plan from contracting with a self-funded employer was pre-empted under ERISA. The court held that although the dental plan was pre-paid, it did not indemnify the plan beneficiaries, and further, that state law traditionally did not view pre-paid plans to be in the "business of insurance." Case law interpreting the definition of "insurance" in the context of provider contracts with employers, however, is limited and sometimes contradictory. Cases like *Oracare* generally have been limited to single-service providers, such as dental and vision care providers, and most case law predates more recent managed care concepts like capitation.

The American Hospital Association, in an AMA-endorsed white paper on the issue, and other legal experts maintain that employers, not providers, should retain the financial risk of direct contracting. "Self-insured employers are, in essence, acting as their own insurance companies," said James S. Matthews, an attorney with Lindquist & Vennum in Minneapolis, at a recent NAIC hearing. "The best place to regulate direct contracts is at the employer level, not downstream at the provider level."

The potential state regulatory obstacles surrounding capitated direct contracts likely will remain a problem for some provider groups until a major court decision resolves the issue. Until then, however, many provider groups can continue to contract directly under various fee-for-service arrangements.

While many state regulators likely will be reluctant to challenge a direct contract firmly grounded in a fee-for-service arrangement, provider groups that face particularly onerous or stringent state regulatory opposition to direct contracting may want to consider legislative or grassroots political action to advance their cause. Proponents in several states, including Minnesota, have begun considering legislation to advance direct contracting.

continued

*See, for example, *NGS American, Inc., v. Barnes*, 998 F 2d 296 (5th Cir. 1993) (state regulators may regulate TPA relationships with fully-insured plans, but not TPA relationships with self-insured plans).

ERISA Restrictions

ERISA was enacted to regulate employee benefit plans, and certain ERISA requirements restrict direct contracts between providers and employers. Of particular concern for providers is avoiding a potential violation of ERISA fiduciary duty requirements. For example, ERISA prohibits any pooling of a plan's trust funds for employee benefits with other funds unrelated to that purpose. Thus, a provider group that accepts and commingles capitated payment funds from more than one employer risks a possible violation of ERISA.

No cases involving physician liability for breach of fiduciary duty to a plan have been reported. Generally, a physician group contracting to provide services to a single self-insured plan would not be considered to be acting in a fiduciary capacity. However, physician groups interested in direct contracting with more than one employer should consider contracting with a third-party administrator to ensure that they meet applicable ERISA fiduciary obligations regarding plan assets.

Other ERISA-based actions are starting to be tested as consumer and provider groups opposed to capitation begin to try new legal theories. In late December 1995, Brown and Seymour, a New York City law firm whose clients include the League of Physicians and Surgeons, filed another in a series of anti-managed care actions. This action, brought on behalf of plaintiff Marla Maltz and her two children, charged that the capitated fee system of Aetna Health Plans of New York violates ERISA requirements that plans act "solely in the interest of the participants and beneficiaries." According to attorney Whitney Seymour Jr., who represents Maltz, capitated payment arrangements "are in the interest of the insurers, not the participants and beneficiaries."

Aetna's move to capitation forced the Maltz family's pediatrician to leave the plan, in effect harming the health care of her children, who suffer from a chronic intestinal disease and may now have difficulty receiving quality, ongoing specialty care,

Seymour said.

Aetna's experience in this case is well worth monitoring by provider groups interested in dealing directly with employers for the provision of employee health benefits.

Antitrust Action

Antitrust actions are another legal risk providers may face in forming

"The federal agencies with jurisdiction over antitrust have taken a restrictive view of physician network joint ventures that market their services to purchasers."

direct contracting relationships. Section 1 of the Sherman Act prohibits "contracts, combinations, or conspiracies" that unreasonably restrain trade. Thus, provider groups should undertake any joint action, such as direct contracting arrangements with employers, with caution in order to avoid antitrust liability.

Unfortunately, the federal agencies with jurisdiction over antitrust—the U.S. Department of Justice and the Federal Trade Commission—have taken a restrictive view of physician network joint ventures that market their services to purchasers. When physician groups are fully integrated or merged, they may negotiate prices with employers without violating antitrust laws. However, a specialty network composed of solo practitioners or small non-integrated groups may risk antitrust violations for price fixing if the separate physicians attempt to band together to form a PPO or group for negotiating prices for direct contracting purposes. Under guidelines issued in late 1993 and clarified in 1995, the agencies created antitrust "safety zones" or size limits for physician-sponsored net-

works or plans. To qualify for safety zones under these guidelines, an exclusive provider network must engage in "substantial risk sharing," such as capitated agreements or withholds, and must have no more than 20 percent of its physicians in a market, in aggregate and by specialty. Non-exclusive networks must engage in substantial risk sharing and must include no more than 30 percent of the physician market.

Larger networks are not necessarily illegal, provided that they engage in substantial risk sharing. However, these networks will be scrutinized under the antitrust "rule of reason" analysis to determine whether they are in compliance with the law. FTC and DOJ opinions have indicated that when a network comprises 35 percent or more of the market's physicians, the network will be scrutinized; when the target exceeds 40 percent, the network is likely to be challenged. Physicians interested in direct contracting should obtain legal counsel to assure compliance with both federal and state antitrust provisions.

Physicians participating in capitated arrangements will enjoy some antitrust protections, but they will still be subject to size limits. Moreover, the agencies' definition of "substantial risk" does not offer great advantages to provider groups, because the safety zone: 1) still requires risk sharing even for groups with small percentages of the market; 2) does not take physician participation in multiple plans into consideration in establishing the maximum allowed participation percentage; and 3) does not recognize physicians' pooling of capital assets as a form of risk sharing. Considering the other potential hazards of capitation and risk sharing, such as insurance regulation, physician participation in "substantial risk" arrangements may not offer enough antitrust protection to offset other legal concerns.

Tort Liability

As in any managed care or health plan contract, the physician group involved in direct contracting must ensure that it retains tort liability limited to the groups' own actions,

and not, for example, for the acts or omissions of the employer sponsoring the plan.

Physicians participating in direct contracting, depending on the structure of their network or group, must also determine whether the group will assume a certain portion of liability or indemnify all participating physicians, or whether individual physicians will retain responsibility for their own liability as independent contractors.

Proper contractual drafting can help physicians avoid being held vicariously liable for the negligent acts or omissions of others and can structure the legal relationships among the participants, defining where tort liability falls. Because physician groups that wish to deal directly may well face additional liability for negligent supervision, negligent credentialing, and other emerging theories of vicarious liability, they should obtain legal counsel and carefully consider those aspects before entering any direct contracting agreement.

Conclusion

Physicians may find contracting directly with employers well worth considering; however, as with all business relationships, they must be aware of the legal issues raised by these arrangements. Certain health care markets appear primed for direct contracting; whether it catches on and becomes the primary model of health care delivery remains to be seen. Currently, however, direct contracting offers great promise as a strategy for physicians to gain and hold control of their local health care markets.

MM

Carol O'Brien is a senior attorney in the Health Law Division of the American Medical Association.

REFERENCES

1. 29 U.S.C. Sections 1001-1461.
2. Section 514 of ERISA (29 U.S.C. Section 1144)
3. Section 514(b)(2)(A) of ERISA (29 U.S.C. Section 1144(b)(2)(A)).
4. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985).
5. 13 E.B.C. 2720 (D.N.J. 1991) *vacated on other grounds*, 972 F. 2d 519 (3rd Cir. 1992).

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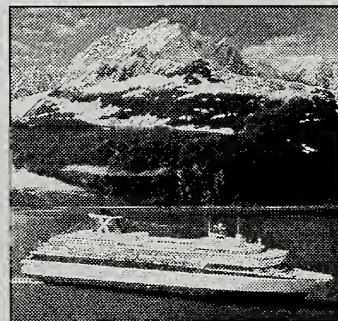
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References

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Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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Baby, I've Got the Blues

Postpartum Depression

Physicians should be prepared to diagnose and treat postpartum blues, a condition that affects up to 85 percent of new mothers.

Barbara P. Yawn, M.D., M.Sc.

Pregnancy outcomes have become a public health issue and major concern for practicing physicians, as well as clinical, health services, and policy researchers. As maternal mortality has declined to acceptable levels, the focus of concern has shifted to the birth of healthy, full-term infants. But it is important to reassess the adequacy of maternal outcomes, as well.

The first year postpartum is often a turbulent time for new families. Much of the turmoil is simply related to incorporating the demands and needs of a new and dependent infant into what is usually a busy and already cluttered family schedule. But in addition, up to 85% of all women experience some depressive emotional reactions in the immediate postpartum period. While most reactions are short-lived, 10% to 25% of the women will experience a major depression within the first year postpartum.¹ The frequency and potential consequences of this major depressive reaction following the most common medical diagnosis in this country—pregnancy—makes postpartum depression a problem of the scope to be considered public health in nature.

SCOPE OF THE PROBLEM

Postpartum depressive reactions are usually divided into three categories: postpartum blues, postpartum depression, and postpartum psychosis. These three conditions have different times of onset, different intensities, and different durations. The most common and least well defined is postpartum blues.

POSTPARTUM BLUES

Postpartum blues are generally characterized as occurring in the first two to three days to two weeks postpartum and consist of feelings of weepiness, emotional lability, and episodes of crying. The mother may express feelings of self-dislike, blues, or merely a desire to cry for no apparent reason.² Women with postpartum blues do not appear to have an increased risk for the more prolonged and severe postpartum depression.^{1,3-6}

Few useful risk factors have been identified to help predict postpartum blues. A history of affective disorders,

a history of premenstrual depressive symptoms, and increased medical⁷ and psychological^{3,5,8} stresses during pregnancy may increase the likelihood of postpartum blues. Women who were found to experience higher levels of anxiety and depressive symptoms during the third trimester of pregnancy also continue to have more depressive symptoms in the first three weeks postpartum.⁹ Postpartum changes in prolactin, progesterone, estradiol, estriol, and cortisol are not predictive of postpartum depression.^{1,2,10} From a public health perspective, identifying the risk factors for a condition that occurs in as many as 85% of women postpartum and changes hourly seems futile.

Treatment for postpartum blues is reassurance and support. In the past, most women experienced the "baby blues" before being discharged from the hospital and were reassured of the condition's benign nature by experienced newborn care and postpartum nurses. Reassurance offered by other new mothers who experienced similar reactions was also comforting. Today's typical 12- and 24-hour postpartum stays result in baby blues occurring primarily at home, where the new parent(s) may have no emotional support or professional counsel from nurses and physicians.

POSTPARTUM DEPRESSION

Postpartum depression occurs in as few as 3% and as many as 30% of women studied during the first year postpartum. The lowest percentages are found in studies that ask women about postpartum depression one to two years after a child's birth.⁸ Prospective studies find postpartum depression rates of 20% to 30%.⁹ These findings should not be surprising; diagnoses sought in retrospect are often reported less frequently.

The diagnosis of postpartum depression is based on the same criteria as those for any major depression (see Table 1). Symptoms may begin at any time postpartum, but the usual onset is soon after delivery, with the median onset of symptoms at two weeks postpartum. Like other major depression, postpartum depression may require treatment for six months to one year after the resolution

Table 1

Symptoms of a major depressive episode

1. Dysphoric mood or loss of interest or pleasure in all or almost all usual activities and pastimes. This mood disturbance should be prominent and relatively persistent.
2. At least four of the following symptoms should be present almost every day for a period of at least two weeks:
 - Change in appetite or weight, apart from changes caused by dieting or other definable causes.
 - Insomnia or hypersomnia.
 - Psychomotor agitation or retardation.
 - Loss of interest or pleasure in usual activities or decreased libido.
 - Loss of energy, fatigue.
 - Feelings of worthlessness, self-reproach, or excessive or inappropriate guilt.
 - Complaints or evidence of diminished ability to concentrate, such as slowed thinking or indecisiveness.
 - Recurrent thoughts of death, suicidal ideation, wishes to be dead, or suicide attempt.

Table 2

Symptoms associated with major psychosis

- Incoherent or loose associations
- Delusions
 - often reflect themes of childbirth
- Hallucinations
- Grossly disorganized or catatonic behavior
 - commonly display confusion and manic symptoms

of symptoms.⁸ Twenty percent to 30% of women experience recurrence following subsequent pregnancies.

Studies have found that postpartum depression is associated with the woman's history of past affective disorder; her usual ability to function in her social, family, and work roles; anxiety; feelings regarding child rearing; the perceived difficulty experienced with the child; the number of other children at home; a history of premenstrual depression; and marital/partner satisfaction. However, none of these factors is sufficiently predictive to allow any one group of women to be singled out as high risk.⁹

Postpartum depression in its mild, moderate, or even severe forms may be missed at the first well-baby visit or the six-week postpartum visit, when the emphasis is often on the infant, the family's functional status, the woman's physical recovery, and future contraceptive needs. It may be difficult to distinguish between the symptoms of depression and the fatigue, lack of sleep and sexual functioning, social isolation, and the frustration normally associated with the early weeks of parenting.

Several studies have shown the value of a postpartum depression screening questionnaire administered during the six-week postpartum examination (see figure). The questionnaire is specifically designed for the postpartum period and does not include some of the questions regarding work schedules and sexual activity included in screening instruments such as the Beck depression scale.¹¹

POSTPARTUM PSYCHOSIS

Postpartum psychosis is uncommon, affecting one in 500 to one in 1,000 pregnancies. It is more common in primiparous women and may be associated with a history of previous major psychiatric illness. The symptoms are those of any major psychotic illness (see Table 2). Onset may be as early as the first days postpartum and is almost always within the first three months postpartum. Once recognized, most postpartum psychoses require hospitalization and medications, such as major tranquilizers. Treatment may need to extend over years to a lifetime. Recurrences with future pregnancies may be as high as 20%.⁹

MALE POSTPARTUM DEPRESSION

Male postpartum depression has received very little attention. Only one study in the medical literature explores this phenomenon. It is not surprising that fathers also reported many of the same symptoms of depression and anxiety as women postpartum.¹² Since depression in women in this stressful period is related to coping skills, stressful events, and marital/partner support, it is reasonable to assume that depression in men who become fathers may be associated with similar events. Men may also require treatment with medication, but certainly require support and education regarding appropriate parenting techniques, relationship expectations, and coping skills.

SUMMARY AND IMPACT ON PRACTICE

Depressive emotional reactions in the first six months postpartum are common. Postpartum blues are almost ubiquitous and need to be met with reassurance and support. Very short postpartum stays mean that families may deal with postpartum blues without support from health professionals. Educating all pregnant families regarding the frequent occurrence and benign nature of this problem is important.

Postpartum depression meets the usual requirements for public health screening. It is common, early intervention may improve outcomes, and treatment is effective. Physicians who are not identifying postpartum depres-

Figure

*Edinburgh Postnatal Depression Scale***Instructions:**

Because you have recently had a baby, we would like to know how you are feeling. Please underline the answer that comes closest to how you have felt in the past seven days, not just how you feel today. Here is an example:

I've felt happy:

Yes, all of the time.

Yes, most of the time.

No, not very often.

No, not at all.

This would mean "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past seven days:

1. I've been able to laugh and see the funny side of things:

As much as I always did.

Not quite so much now.

Definitely not so much now.

Not at all.

2. I've looked forward with enjoyment to things:

As much as I ever did.

Rather less than I used to.

Definitely less than I used to.

Hardly at all.

*3. I've blamed myself unnecessarily when things went wrong:

Yes, most of the time.

Yes, some of the time.

Not very often.

No, never.

4. I've been anxious or worried for no good reason:

No, not at all.

Hardly ever.

Yes, sometimes.

Yes, very often.

*5. I've felt scared or panicky for no very good reason:

Yes, quite a lot.

Yes, sometimes.

No, not much.

No, not at all.

*6. Things have been getting on top of me:

Yes, most of the time I haven't been able to cope at all.

Yes, sometimes I haven't been coping as well as usual.

No, most of the time I have coped quite well.

No, I have been coping as well as ever.

*7. I've been so unhappy that I've had difficulty sleeping:

Yes, most of the time.

Yes, sometimes.

Not very often.

No, not at all.

*8. I've felt sad or miserable:

Yes, most of the time.

Yes, quite often.

Not very often.

No, not at all.

*9. I've been so unhappy that I have been crying:

Yes, most of the time.

Yes, quite often.

Only occasionally.

No, never.

*10. The thought of harming myself has occurred to me:

Yes, quite often.

Sometimes.

Hardly ever.

Never.

Scoring: Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptoms. Items marked with an asterisk are reverse scored (3, 2, 1, and 0). The total score is the sum of all item scores. Women with scores of >12 are likely to be suffering from depression.

Reprinted from: Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale (EPDS). *Br J Psychiatry* 1987;150:782-6.

sion in 10% to 25% of their postpartum patients should consider using a screening tool such as the Edinburgh Postnatal Depression Scale¹¹ at the six-week postpartum visit.

Fathers may experience the same levels of depressive symptoms as women in the postpartum period. Studies suggest that men have greater difficulty finding emotional and psychological support during this stressful time, especially men whose partners are experiencing depres-

sion and anxiety. Women often turn to other women: colleagues at work or female relatives or friends. Men usually choose their partners as their source of emotional support and find little support at work or from male relatives or friends. In this day of broken extended family groups, postpartum men also deserve evaluation and suggestions for therapy, counseling, or support for postpartum depressive symptoms.

Postpartum depression should be added to the myr-

iad concerns physicians deal with in the ongoing care of the pregnant family. **MM**

Barbara Yawn is a family physician and director of clinical research at the Olmsted Medical Group in Rochester, Minnesota, and a member of the Minnesota Medicine Advisory Committee and editor of the Minnesota Medicine Public Health Reports.

REFERENCES

1. O'Hara MW. Social support, life events, and depression during pregnancy and the puerperium. *Arch Gen Psychiatry* 1986;43:569-73.
2. Bonin F. Cortisol levels in saliva and mood changes in early puerperium. *J Affective Disord* 1992;26:231-40.
3. Kennerley H, Gath D. Maternity blues: associations with obstetric psychological and psychiatric factors. *Br J Psychiatry* 1989;155:367-73.
4. Harris B, Huckle P, Thomas R, Johns S, Fung H. The use of rating scales to identify post-natal depression. *Br J Psychiatry* 1989;154:813-7.
5. Gard PR, Handley SL, Parsons AD, Waldron G. A multivariate investigation of postpartum mood disturbance. *Br J Psychiatry* 1986;148:567-75.
6. Tsukasaki M, Ohta Y, Oishi K, Miyaichi K, Kato N. Types and characteristics of short-term course of depression after delivery: using Zung's self-rating depression scale. *The Japanese Journal of Psychiatry and Neurology* 1991;45(3):565-76.
7. Burger JA, Horowitz SM, Forsyth BWC, Leventhal JM, Leaf PJ. Psychological sequelae of medical complications during pregnancy. *Pediatrics* 1993;91(3):566-71.
8. Boyce P, Hickie I, Parker G. Parents, partners or personality? Risk factors for post-natal depression. *J Affective Disord* 1991;21:245-55.
9. Gjerdingen DK, Froberg DG, Wilson DL. Postpartum mental and physical problems: how common are they? *Postpartum Health* 1986;80(8):133-45.
10. O'Hara MW, Schlechte JA, Lewis DA, Wright EJ. Prospective study of postpartum blues. *Arch Gen Psychiatry* 1991;48:801-6.
11. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: development of the 10-item Edinburgh Postnatal Depression Scale (EPDS). *Br J Psychiatry* 1987;150:782-6.
12. Richman JA, Raskin VD, Gaines C. Gender roles, social support and postpartum depressive symptomatology. *J Nerv Ment Dis* 1991;179(3):139-47.

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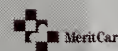
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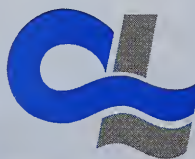
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ANNOUNCEMENTS

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MMA AND MMGMA WILL PRESENT LEADERSHIP SEMINAR

The Minnesota Medical Association and the Minnesota Medical Group Management Association are co-sponsoring a half-day seminar, "Building Leadership for Change," on Wednesday, February 28 at the Hyatt Hotel in Minneapolis. The speaker, Jack Silversin, D.M.D., Dr.Ph., will help health care leaders enhance their organization's ability to compete in changing markets. The program will look at some of the fundamental shifts taking place in medical care delivery and discuss what it will take for physicians to master these changes and continue to be professionally satisfied. Topics include:

- new roles for physicians in health care delivery,
- new opportunities, and
- coping with change.

The registration fee is \$50. For more information, call Karen Tourdot at the MMA, 612/378-1875 or 800/999-1875.

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TWIN CITIES HOSPICES ANNUAL GENTLE JOURNEY CONFERENCE

"Palliative Medicine's Approach to the Relief of Suffering"
March 7, 1996
6 p.m. to 8 p.m.
Sheraton Inn-Midway
St. Paul, Minnesota

Laurel Herbst, M.D., president of the American Academy of Hospice Physicians and medical director of the San Diego Hospice, will discuss palliation as a way to relieve the patient's suffering and admission to hospice and palliative care for patients with non-cancer diagnoses. The registration fee is \$25. For more information, or to register, call HealthEast Tele-Health, 612/232-2600.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Wins Major Victory in Negotiations with BMP

After months of negotiation, the Minnesota Medical Association and the Minnesota Board of Medical Practice have reached agreement on the proposed changes in the BMP's disciplinary procedure and have managed to avoid a battle at the Legislature.

In a significant compromise, the BMP has agreed not to seek legislation that would allow the board to share the information that it gathers during its investigations with law enforcement agencies. The MMA successfully argued that this would rob physicians of their constitutional right not to incriminate themselves. During a BMP investigation, physicians cannot decline to answer questions that might incriminate them or they risk disciplinary action, including possible suspension of their medical licenses. The MMA also maintained that the BMP proposal was not necessary. Current law gives the BMP the authority to report to law enforcement agencies if there is a clear and present danger to the public.

One of the sticking points in negotiations has been whether or not to allow the notice of a contested case hearing to be made public. The MMA contended that allowing unproved allegations to be published before the hearing could destroy an innocent physician's practice. The BMP argued that making the notice public was appropriate because con-

tested hearings take place only when a physician rejects BMP sanctions and requests a hearing before an administrative law judge (ALJ)—a rare occurrence that happens fairly late in the process. (For more information about the BMP disciplinary process, see related article on page 34.) In an important compromise, the board has agreed to limit this change in the law to cases involving allegations of physician sexual misconduct and to add an additional step in the process to act as a speed bump and protect the innocent. The ALJ would be required, upon request, to make a finding of "probable cause" before notice of a contested case hearing could be made public.

In exchange for the MMA's willingness to compromise, the BMP has also agreed to set a statute of limitations in the Medical Practices Act. Under the new proposal, the BMP would not proceed if more than seven years had passed after any portion of the offense occurred except in complaints regarding sexual misconduct. This is a major concession by the BMP. The MMA has long sought a statute of limitations.

One issue remains under discussion. The MMA would like the BMP consultants' report to be available to physicians before the initial discipline conference. Negotiations on this issue are expected to continue for the next year. • • • • •

A Quick Look at the BMP Disciplinary Process

ANNOUNCEMENTS

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SLIDES ARE AVAILABLE

The MMA has up-to-date slides giving an overview of the Medicare and Medicaid debate in Washington. If you would like to borrow these slides for a presentation, contact Janet Silversmith at the MMA, 612/378-1875 or 800/999-1875.

• • •

CROSS-CULTURAL HEALTH COURSE IS OFFERED

This spring, the Minnesota International Health Volunteers will once again offer its 12-week course, "Orientation to International Health Service." Classes will be held on Tuesday evenings from 6:30 p.m. to 9 p.m., March 5 to May 21, 1996, at the Minnesota Church Center in Minneapolis.

This course is designed for health care professionals and students who plan to live or work abroad, particularly in developing countries. Classes present the fundamentals of international and cross-cultural health in a social, political, economic, and cultural context. The course is a prerequisite for persons with no prior overseas experience who wish to serve abroad with MIHV.

Participants are eligible for academic or continuing education credit, including 24 CME hours. For more information, please contact Patricia Ohmans or Michael Jefferis at MIHV, 612/871-3759.

The Minnesota Board of Medical Practice consists of 16 members, appointed by the governor, 10 of whom are physicians. The BMP's disciplinary process is briefly outlined below.

Investigation and Screening

When the BMP receives a complaint, its staff and a medical coordinator analyze the allegations. Investigators may collect information such as medical records, consultants reports, etc. The physician may be asked to submit a written response or come to the BMP for an interview. This process may take weeks or months. The information gathered during the investigation goes to a complaint review committee for screening. The committee may: 1) dismiss the complaint, 2) recommend that the full board impose discipline, or 3) call for further investigation by a complaint review committee or medical coordinator. The information gathered during the investigative process is confidential. Most complaints are dismissed.

Medical Coordinator

In the case of minor complaints, the medical coordinator meets with the physician to discuss the allegations. Following these sessions, complaints are usually dismissed and there is no public record.

Complaint Review Committee

In the case of more serious allegations, a three-member complaint review committee conducts a conference at which the physician responds to the allegations and answers questions. This conference is closed to the public and information on the case is confidential. The complaint review committee may 1) dismiss the complaint, 2) send the case back for further investigation, 3) recommend disciplinary action, 4) recommend a corrective action agreement in which the physician agrees to certain stipu-

lations in exchange for ultimate dismissal of the case, or 5) recommend referral to the Health Professional Services Program for treatment and monitoring of an impairment. The BMP almost always accepts the recommendation of the complaint review committee.

Contested Case Hearings

Contested case hearings take place only if the physician rejects the disciplinary action and requests a hearing before an administrative law judge (ALJ).

Proposed changes in the BMP process would insert a new process at this point for cases involving sexual misconduct—the probable cause hearing. Upon request, the ALJ would have to convene a hearing, then issue a finding of "probable cause" in order to make the notice of the contested case hearing public. During the hearing, the physician would be able to present evidence and cross examine witnesses on the issue of probable cause that a violation of the Medical Practices Act occurred. Before the probable cause hearing, the physician would find out who made the complaint. Under current law, this information becomes available before the contested case hearing.

Following the contested case hearing before the ALJ, the BMP, not the administrative law judge, makes all final decisions regarding disciplinary sanctions. In making these decisions, the BMP considers, among other things, the report and recommendations of the ALJ, which are issued following the conclusion of the contested case proceeding. Contested case hearings are rare. Final disciplinary action by the BMP is public information.

Court of Appeals

Following final action by the BMP, the physician has the right to appeal to the Minnesota Court of Appeals.

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Medical Assistance Task Force Completes Report

MMA Prepares for Debate on State Programs

Plans to revamp Medical Assistance and other state-subsidized health care programs are expected to dominate the 1996 Minnesota legislative session. Despite the current stalemate between Congress and the Clinton administration over Medicaid, Minnesota legislators will probably go ahead and consider ways to cope with the expected loss of federal money for Medical Assistance (MA), the state's Medicaid program, rather than waiting for agreement in Washington.

There are several proposals on the table. The Department of Human Services wants the state to switch its role from provider to purchaser of MA health care coverage. Under this proposal, the state would contract with health plans, health cooperatives, and provider networks to provide care for a capitated amount. There are also proposals to merge MinnesotaCare, Medical Assistance, and General Assistance Medical Care, and to use copays and deductibles for public programs.

To prepare the MMA to be an active player in this debate, the MMA Ad Hoc Task Force on Medical Assistance, chaired by Timothy Crimmins, M.D., has been developing policy recommendations regarding Medical Assistance and the state's other subsidized health care programs. The following recommendations will be considered by the MMA Executive Committee.

- Seek immediate repeal of the \$400 surcharge. Support a moderate increase in the cigarette or alcohol tax as a way to replace the approximately \$4 million the surcharge raises. The surcharge was originally enacted in conjunction with a one-time increase in MA reimbursement as a way to draw additional matching funds from the federal government. Although only physicians paid the surcharge, the 1992 MA increase

went to many other types of providers as well. If the block grant proposal is adopted, the surcharge would no longer increase the federal matching dollars that Minnesota receives each year.

- Support universal health care coverage. Congress should establish national standards for benefits and eligibility so that states like Minnesota will not be magnets for residents of other states that choose to offer limited services.

- Support sliding-scale premiums for state program enrollees who earn more than the federal poverty level.

- Support copays for state program enrollees. The copayment system, however, should be administered by the state and/or by contracted health plans and tested on a pilot-project basis. Providers should not be responsible for collecting the copay.

- Oppose any change from the current three-month retroactive eligibility period to a one-month period to protect providers from uncompensated care costs.

- Support a standard benefits set for public and private insurance plans. Until a statewide standard benefits set is developed, the MMA should support a benefits package for public programs that approxi-

mates the levels found in the private market. The task force noted that public program enrollees may need additional services such as transportation or language translation. If financial constraints become severe, the MMA should support a limited reduction in covered benefits before a reduction in eligibility levels.

- Support the administrative integration of the state programs but not financial integration. The Health Care Access Fund should fund only the MinnesotaCare program. The General Fund and federal funds should pay for MA and GAMC.

- Support changing the role of the Minnesota Department of Human Services from a regulator/payer of health care services to a purchaser of coverage on behalf of public program enrollees. The health care coverage purchased by DHS should, however, allow a variety of delivery arrangements and should not be limited to care delivered through HMOs, CISOs, or PPOs. The rate at which DHS is converting to managed care should be slowed to allow providers and patients time to respond.

- Oppose any cuts in provider reimbursement.

- Recognize the need for the reform of long-term care service delivery and financing.

The MMA Executive Committee will decide whether these recommendations will become MMA policy.

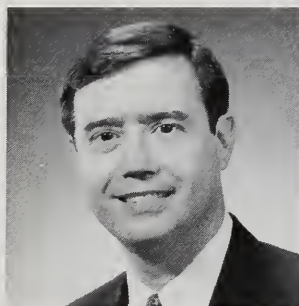
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Peer Review Program

• • • • • THE MINNESOTA MEDICAL Association now offers a peer review consultation service to help physicians and health care organizations with the investigative phase of peer review. The MMA developed the program because some hospitals and clinics have difficulty finding specialists or non-competing physicians to conduct peer review.

The MMA Peer Review Con-

sultation services offers either a one-day, on-site visit or a medical record review followed by a comprehensive, confidential report. The process is strictly advisory and allows the medical staff and facility to reach its own decision. For information about the consultation service, please contact Katherine Kennedy, J.D., Peer Review Program Director, at 612/378-1875.



Viewpoint

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Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

Why Is Violence Increasing? What Can We Do?

Recently, the Minnesota Medical Association signed a contract pledging us to do all in our power to diagnose and treat the epidemic of violence.

It will be an uphill struggle.

- In Minnesota, gun homicides increased by more than 65 percent in the last five years.

- For children aged 13 to 17, gunshot wounds were the leading reason for trauma admission to Hennepin County Medical Center in 1992.

- Arrests of juveniles for violent crimes increased by 44 percent in Minneapolis and by 66 percent in St. Paul from 1993 to 1994.

Why has there been this tremendous upswing in violence? Certainly, as the MMA has been pointing out in its campaign against media violence, the brutality of movies, television, and video games is partly to blame.

Ten years ago, I went with my family to see "Beverly Hills Cop" and was horrified at the gratuitous violence. When the "bad guy" was killed in a brutal execution, the audience laughed and cheered. I was so horrified I left the theater. My family told me to lighten up; it's just a movie, a comedy. But I couldn't see the humor in killing. As an emergency physician, I see the real thing in my practice and I see the suffering of

the families.

Since then I have noticed how a steady diet of violent movies has influenced children. Kids say, "Make my day," imitating the Clint Eastwood character. When you think about it, this is a chilling phrase—If you anger me, I will kill you, and this will make me happy. The media is teaching values to our children. Heroes enjoy the opportunity to kill. Violence is a good way to solve a problem. Guns empower.

If we examine the reasons why violence is increasing, we see many people engaged in a daily economic struggle. Large corporations have replaced small shops, workers are laid off, the feeling of community has eroded. The gap between the "haves" and "have-nots" has widened in the past 10 years. It is increasingly difficult for someone who is not well educated to get ahead simply by working hard. Poverty often leads to frustration, hostility, anger, and sometimes violence.

In a Twin Cities *Star Tribune* article, a boy described how his honest, hard-working father struggled to support his family. His father was a disappointment to the boy. He admired his older brother who joined a gang, sold drugs, and became rich. It seems that a generation of children, who are growing up in poverty, see drugs and violence as pre-

ferred options to hard work.

For many who are struggling for economic survival there is a growing feeling of powerlessness and lack of self-esteem. Weapons are readily available. For some, guns seem the only way to acquire power and money. These people often end up in the emergency department.

But the problem of violence is by no means confined to those in economic difficulty. Domestic abuse can occur in any neighborhood and violence in the workplace is increasing. Guns escalate the violence, raising the odds that someone will be killed.

The roots of violence are complex. Media violence. Alcohol and drugs. Lack of self-esteem rooted in poverty. Easy access to handguns. Lack of impulse control in teenagers.

So what can we do? Certainly, there will be no quick fix. In signing the contract, we agreed to take the steps we *can* take. (See page 38.) The MMA is also initiating legislation that calls for safe storage of firearms in homes with young people under age 18. We are forming coalitions with other groups. In addition, the MMA continues to distribute guidelines on media violence and on domestic violence.

In our practice, we can watch for children at risk, those with low self-esteem or little impulse control and then work with parents to boost the children's self esteem or recommend counseling. We can identify and refer victims of domestic violence. We can ask if firearms are safely stored.

As individuals, we can support programs in our community that teach people to resolve conflicts without violence and help them develop social skills. We can support fair wages in our community so there will be rewards for hard, honest work. We can express our opinions about violent programming to the entertainment industry and to companies that advertise.

It will not be easy to transform our society. We are just beginning.

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Youth Summit Attracts Media Coverage for MMA Gun Lock Bill

The MMA gun lock legislation was introduced amid a blaze of publicity for the Youth Summit in St. Paul January 17. Front page stories appeared in the metro sections of both Twin Cities major newspapers and there was extensive broadcast coverage of the summit, which was sponsored by the Minnesota Medical Association, the office of Attorney General Hubert H. Humphrey III, and the University of Minnesota's Minnesota Center for Community Legal Education at the Center for 4-H Youth Development. (See related article on page 8.)

The MMA bill would amend the negligence statute regarding storage of firearms in homes where children live by raising the age of a "child" from 14 to 18 and defining the standard that prosecutors would use, if a tragedy occurred, to determine whether someone had stored a gun with reasonable caution. A stored firearm in a home with children under age 18 would have to be locked with a trigger lock, barrel lock, or cylinder lock, or be placed in a locked gun case or safe.

The bill's author, Sen. Jane Ranum, DFL-Minneapolis, introduced the bill to about 200 junior high and high school students who had traveled from across the state to attend the summit. "The world is run by those who show up," Ranum told them, echoing one of the summit's guiding principles. "Legislators want to hear from the people who will be most affected by a bill. The most powerful testimony I've heard at the Capitol has come from real folks in the real community. Unfortunately, gun violence is an issue that too many of you must deal with on a regular basis." The truth of Ranum's remark was illustrated later. When the students were asked how many of them knew someone personally who had been killed by gunfire, most raised their hands.

In roundtable discussions, stu-



Sen. Jane Ranum, DFL-Minneapolis, and Attorney General Hubert H. Humphrey III.

dents listened to supporters and opponents of the bills and shared their own experiences. One girl said she had been baby-sitting for a six-year-old boy who came running to show her his father's gun. Fortunately, it was in a locked gun case, so even though the child pounded on the keys of the combination lock, he couldn't get it open. A similar incident ended tragically. Douglas Brunette, M.D., an emergency physician at Hennepin County Medical Center, told the students he had recently taken care of a five-year-old boy who found a handgun, shot himself in the face, and died.

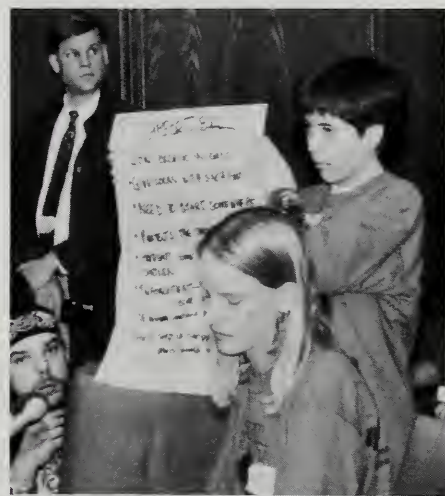
Attorney General Hubert Humphrey III and Mayor Sharon Sayles Belton urged support for the gun lock bill. "As a mayor and a mother, I will work hard to reduce the risk of firearms," Sayles Belton said. "This bill would help make guns less accessible. The legislation addresses the impulsiveness associated with violent crimes such as suicide, unintended gun deaths, and fit-of-rage shootings. It gives time to cool down and chill out."

For the students, the summit was a chance to make their voices heard and to learn about the legislative

process. Most thought the MMA bill was a step in the right direction, but some seemed overwhelmed by the scope of the problem.

Testifying before legislators in a Capitol hearing room, young people described the impact of violence on their lives. "It's so hard to be a kid today," one girl told legislators. "A kid was shot at our school." Some students didn't think the bill went far enough and called for mandatory gun safety education. "The person who has the key doesn't necessarily know how to use the gun safely," a girl said.

Some students said the bill might stop unintentional deaths or suicides, but it wouldn't address the real problem—illegal handguns. A boy said that most of his friends carried guns, but his mom found his and made him sell it. Some said they had to carry guns for protection. "Guns weren't made to look at. On the street, nobody will use trigger locks. If someone shoots you, you're going to be dead."



A supporter of the bill said, "It won't solve the problem of violence, but it will give extra time to think if someone has to go get the key and unlock the gun. It could save children." An opponent said that if he had to go get the key and find the ammunition, before loading his gun and defending his family, his children could be killed.

The problem of how to enforce

Summit continued on page 38

MMA Pledges to Help Reduce Violence Epidemic

At a news conference January 11 in St. Paul, the Governor's Task Force on Violence as a Public Health Problem unveiled a plan outlining ways the health care community can help reduce violence in Minnesota. Task force members, including Andrew J.K. Smith, M.D., immediate past president of the MMA, signed a contract pledging the health care organizations they represent to make every effort to prevent violence and to respond to the victims of violence. The 13-member task force, co-chaired by Lieutenant Governor Joanne E. Benson and Rep. Charlie Weaver, R-Anoka, includes health plan executives, physician and hospital representatives, legislators, law enforcement representatives, and community leaders.

Weaver outlined the scope of the problem. "This was a record year for homicides in Minnesota. Violence costs the health care industry \$200 million a year in Minnesota and \$10 billion nationwide. Often the victim is not insured and the money for treatment comes out of the taxpayer's pocket."

Health care workers are in a unique position to respond to violence, Weaver said. "When a child riding his bike is gunned down, or a

woman is raped, the first person the victim sees may be an emergency physician. A victim of date rape is more likely to confide in a nurse than in a police officer."

Task force members seemed confident they could make a difference. "Over time we can do something to end violence," Smith said. "Violence is a public health issue and it requires a collaborative approach. We have to identify the root causes of violence and improve awareness and education."

The task force's public health paradigm calls for the following action:

- collect better data on violence in order to identify the incidence, risk factors, and causes of violence;
- support research and evaluation of violence prevention and intervention programs;
- work with other groups to develop and use practice guidelines on responding to violence victims and intervening to prevent violence;
- strive to make workplaces abuse-free through employee education and training; and
- evaluate internal policies for coverage, payment, billings, and staffing, and change policies if they interfere with effective intervention and prevention.

A. Stuart Hanson, M.D., a past president of the MMA who represents HealthSystem Minnesota's Institute for Research and Education on the task force, told reporters that the MMA's Stop the Violence campaign has made a difference in physicians' awareness of domestic abuse. "When the wife of a highly respected individual recently came to the hospital with suspicious injuries, health care workers recognized possible signs of domestic abuse. Five years ago, this probably would not have happened." As part of the MMA Stop the Violence campaign, which began three years ago, the MMA distributes information on the warn-

ing signs of domestic violence and on resources for its victims. Guidelines to help stop media violence are also available.

Theresa Zink, M.D., of HealthPartners, who served on the task force's staff advisory committee, agreed that physicians are more aware of violence now. "I didn't learn about this in medical school. But now when I examine patients I ask if their guns are locked up. I ask about their parenting skills. In her first trimester, I ask a pregnant woman if she is treated in a hurtful way. If I notice suspicious injuries I ask about them. The woman may not tell me right away, but I have opened the door to carry on the conversation later."

Members of the task force also stressed the need to make sure the medical workplace and medical schools are abuse-free. "We have to clean up our own act first," Hanson said.

Now that the task force report has been released, the next step will be to recruit other health professionals, hospitals, and community leaders from across the state to join a larger coalition that will be formed to implement the task force's plan. The larger coalition will be chaired by David Strand, a task force member and president of Medica.

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MMA Domestic Violence Campaign Will Be Highlighted in National Manual

• • • • • THE MMA'S DOMESTIC violence program is among 10 programs from across the country that have been chosen to be featured in a "State-of-the-Art Health Care Response Manual" produced by the Family Violence Prevention Fund and the Pennsylvania Coalition Against Domestic Violence. This manual, highlighting innovative responses to domestic violence, will be disseminated throughout the country.

Summit continued from page 37

the bill troubled some of the students. Supporters said:

"Even if it isn't enforced, this bill will raise awareness of gun safety."

"We put a safety belt on every day. Why can't we put a lock on our guns?"

"One life saved is better than none."

Following the students' presentations, Sen. Sam Solon, DFL-Duluth, said, "Based on your testimony today, I think I know how I'm going to vote on this bill." But he left them in suspense. • • • • •

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ANNOUNCEMENTS

MEDICARE DEFAULT CONVERSION FACTORS ARE IN EFFECT

Since Congress and the Clinton administration have failed to reach agreement on the 1996 federal budget, the Medicare conversion factors used to calculate physician Medicare fees have defaulted under existing Medicare policy to:

Surgery	\$40.80
Primary Care	\$35.42
Non-Surgery	\$34.63

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MDH PROPOSES SINGLE IDENTIFIER FOR PROVIDERS AND PAYERS

The Minnesota Department of Health will seek amendments to existing law that would make administration and billing simpler. Current law requires that beginning in 1998 all providers must use the Medicare Unique Physician Identification Number (UPIN) for state program claims. The MDH proposes this law be amended to require that providers use the National Provider Identifier (NPI) for all claims, public and private, beginning in 1998, and that payers use a standard payer identifier (PAYERID). This amendment would make the state provider identifier the same as the Medicare identifier. HCFA is developing the NPI to replace the UPIN. Federal law requires the use of the NPI for all Medicare claims beginning in 1997. One identifier for all payers and all providers will make administration and billing simpler and will facilitate research efforts.

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POSTPARTUM BILL PASSES OUT OF COMMITTEE

When the 1996 legislative session began January 16, the postpartum care bill, HF 2008-Opatz, was one of the first bills to move forward. The bill, which would require insurance plans to cover at least 48 hours of in-hospital postpartum

health care for a mother and her baby unless the physician and mother decide a shorter hospital stay is appropriate, passed out of the House Health and Human Services Committee on January 18. Michael J. Murray, M.D., president of the MMA, had written a letter of support to the bill's author, Rep. Joe Opatz, DFL-St. Cloud. "Generally speaking the MMA opposes mandates that intervene in physicians' clinical decision-making," Murray wrote. "However, in the postpartum context, we believe that H.F. 2008 is necessary to stem the tide of insurers, health plans, and hospitals that are replacing the physician's judgment of what is best for the patient with what is the cheapest way to pay for health care."

.....

CHAMPUS REQUIRES PRE-AUTHORIZATION OF ABORTIONS, C-SECTIONS, HYSTERECTOMIES

Providers must obtain preauthorization for inpatient abortions, hysterectomies, and cesarean sections for CHAMPUS patients. Although this CHAMPUS requirement has been in effect since 1992, PRO-West has found that many providers are unaware of it.

If a provider performs an inpatient abortion, cesarean section, or hysterectomy before obtaining authorization, the case will be selected for retrospective (paid claims) review and the claim may be denied if the admission and/or procedure is found to be "not medically necessary." Furthermore, the physician may be subject to payment penalties.

In Minnesota, pre-authorization is obtained by calling PRO-West, A Professional Review Organization, at 800/783-2477. Phones are staffed Monday to Friday from 5 a.m. to 5 p.m. When all lines are busy or when staff are not available, physi-

cians may leave a voice mail message, or they may fax a pre-authorization request to 800/431-2565. Authorization must be obtained not more than 30 days, and not less than two working days, before the admission or procedure. If the admission or surgery is urgent or emergent, providers will have up to two working days after the admission or procedure to obtain authorization.

.....

MINNESOTA WON'T APPEAL ABORTION RULING

Attorney General Hubert H. Humphrey III and Gov. Arne Carlson will not seek to appeal the Minnesota Supreme Court decision overturning a Minnesota law that limits abortion coverage under Medical Assistance and General Assistance Medical Care to abortions that are medically necessary to prevent the death of the woman, that are the result of rape or incest, or are performed for health reasons. The court ruled that laws are unconstitutional if they allow public funds to be used for medical care related to childbirth but don't allow public funds to be used for medical services related to therapeutic abortions. Humphrey's office said the decision would not be petitioned for rehearing or appeal.

.....

U OF M REGENTS APPROVE MERGER WITH FAIRVIEW

The University of Minnesota Regents have approved a merger of the University of Minnesota Health System and Fairview Health System. This issue will probably be addressed during the 1996 legislative session. Watch for an article on the proposed merger and the re-engineering of the university's academic health center in the March issue of *Minnesota Medicine*.

A N N O U N C E M E N T S

HAZARDOUS WASTE REPORTING RULES CHANGE

The Minnesota Pollution Control Agency (MPCA) has reduced its hazardous waste reporting requirements for businesses in greater Minnesota. The changes are designed to help businesses complete forms more quickly and easily. There will be less regulatory oversight if waste is being managed appropriately through other programs.

The following changes apply only to businesses located outside the seven-county metropolitan area.

- Businesses, such as physician clinics, that produce only silver bearing waste that is treated before being sewerage no longer are required to report. These businesses should not have received an application form this year.
- Businesses that produce only oily waste (such as used oil, oil filters, and oil sorbents) are no longer required to be licensed or to report the oily waste on their licenses. The oily wastes will not show up on the waste inventory. Oil-only generators were not sent an application form. Instead, oily waste transporters must report the volumes of these wastes to provide a more accurate statewide total of wastes being produced.
- Businesses that produce less than 10 gallons of total hazardous waste will no longer be required to have a license, but they must still manage their waste as hazardous.
- For businesses that produce hazardous wastes in addition to silver bearing wastes, the silver bearing wastes will not show up on the waste inventory if waste is treated prior to being sewerage to a sanitary sewer. These wastes no longer need to be reported.
- Wastes that are now managed under a special waste program such as fluorescent/HID lamps, house-

hold-type batteries, and rags that may contain oils, paint waste, or other contaminants, are also exempt from the licensing requirement.

These wastes will not show up on the waste inventory.

The MPCA is looking for additional ways to reduce the regulatory burden and the administrative cost. Currently, the MPCA is exploring the possibility of removing the reporting requirements for waste antifreeze. Please send the MPCA any test data that would help in making this decision.

For more information about hazardous waste reporting, call 800/657-3724 or 612/297-8362.

RURAL NETWORK DEVELOPMENT GRANT MONEY IS AVAILABLE

Grant money is available through the Minnesota Department of Health's Office of Rural Health and Primary Care for rural Minnesota communities that are interested in developing local Health Care Cooperatives or Community Integrated Service Networks (CISNs).

To be eligible, the proposed network must be:

- based in a rural area,
- sponsored and controlled locally,
- focused on primary care,
- established, or planning to be established, as a CISN or health care cooperative, and
- able to demonstrate the availability of local dollar-for-dollar matching funds (the matching requirement does not apply to networks applying for planning grants).

The request for proposals packet is available upon request from Molly McCormick, Office of Rural Health and Primary Care, at 612/282-6304 or 800/366-5424. The deadline for

submission of applications is February 16, 1996.

HCFA COMMON PROCEDURAL CODING SYSTEM MANUALS ARE AVAILABLE

In the past, the Health Care Financing Administration Common Procedural Coding System Manual was provided free of charge to providers and suppliers. Because of the increased cost of production and distribution, however, there will be a charge for the 1996 manual. The 1996 HCPCS Manual will include Level II-national codes, Level III-local codes, and DHS codes, which are new for this year. To obtain a manual, call the Minnesota Bookstore at 612/297-3000.

The Monitor

FEBRUARY 1996

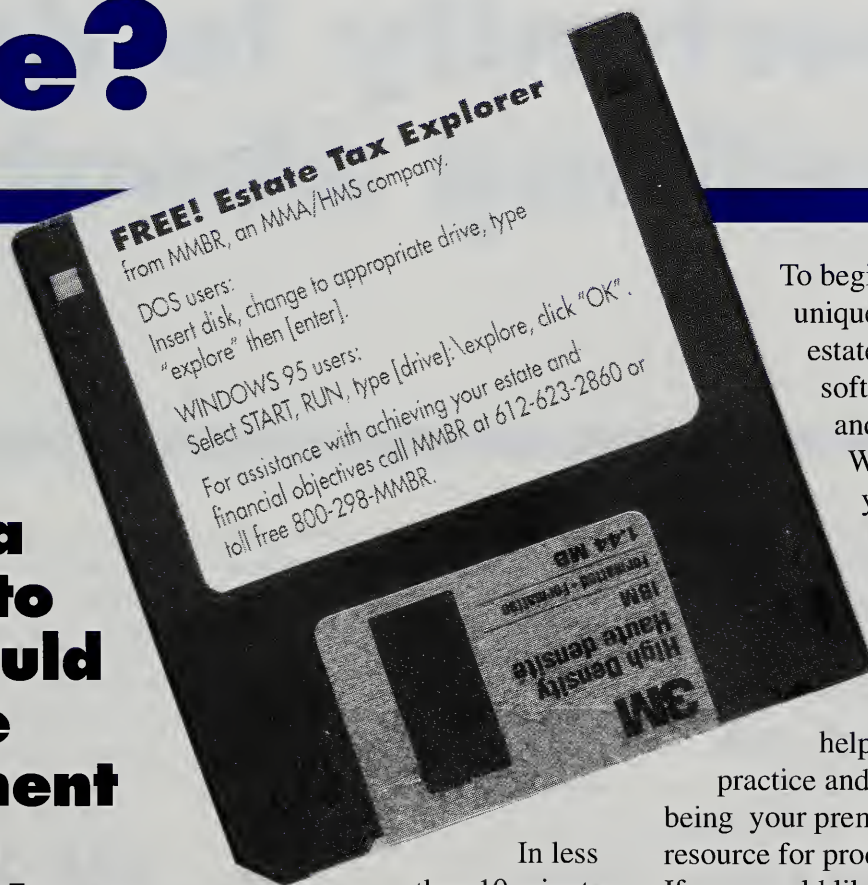
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The Medicaid Fray

Escalating costs and fundamental questions about the government's role in providing a health care safety net are fueling the Medicaid reform debate.

Janet Silversmith

Medicaid is referred to as the health insurance "safety net" for good reason: the program provides health care coverage for 25 percent of the country's children, pays for 33 percent of all births, pays for 50 percent of all nursing home care, and accounts for 13 percent of total health care spending.¹ Medicaid's presence, however, comes at a high price; the program's expenditures reached \$131 billion in 1993, a doubling since 1988.² This recent growth in Medicaid costs, attributed to general health care inflation, states' use of alternative financing mechanisms (provider-specific taxes and voluntary donations), and an increase in enrollment,³ has created intense debate about the ability of federal and state governments to afford the program.

Republican efforts to craft a balanced budget proposal by 2002 have drawn congressional attention to the Medicaid program. The Republicans' Medicaid plan (vetoed with the rest of the Omnibus budget bill by President Clinton on December 6, 1995) called for a reduction in expected spending of \$133 billion over seven years. This article describes the Medicaid program nationally and in Minnesota and highlights the major provisions of congressional plans for reform.

MEDICAID: A BRIEF HISTORY

Medicaid was passed by Congress in 1965 as Title XIX of the Social Security Act. Its origin, however, can be traced back several decades earlier. The concept of a social welfare system was realized with the passage of the Social Security Act in 1935 (a social insurance program for the working population and a public assistance program for the unemployed). This legislation did not explicitly provide for health care coverage, but an individual's medical costs were included in determining the amount of public assistance. In 1950, the Social Security Act was amended to authorize federal matching funds to be used by state public assistance programs to reimburse public assistance recipients' health care expenses. In 1960, Congress passed the Kerr-Mills Act, which further expanded federal support for medical care for low-

income persons. The Kerr-Mills Act defined a new category of eligible individuals—the medically indigent—people with incomes above the requirements for public assistance, but below what they need to cover their health care expenses. As was true with the earlier amendments, state involvement was optional. With the passage of Medicaid, Congress created a program with three distinct features: 1) joint federal-state financing; 2) state administration in accordance with broad federal standards, and 3) linkage of eligibility to state standards for cash welfare benefits.⁴ The program remains voluntary for states, but since Arizona joined in 1982, all 50 states participate.

GENERAL DESCRIPTION

The Medicaid program is a means-tested entitlement program financed by federal and state government and principally administered by the states.* Financing is shared by the federal government and the states. The federal government's contribution (known as the Federal Medical Assistance Percentage) is based on a state's average per capita income level compared with the national average. The federal contribution can be no less than 50 percent and no greater than 83 percent of a state's total Medicaid program costs. State revenue can be generated at the state or local level, but the state is responsible for at least 40 percent of the non-federal share.²

Although Medicaid is an entitlement program, it does not guarantee coverage to all low-income individuals; in fact, in 1993, the Medicaid program covered only about 32 percent of poor Americans, leaving nearly 29 percent of poor Americans uninsured.[†] Eligibility for

*The Health Care Financing Administration is the administrative agency at the federal level.

†Poor is defined as below 150 percent of the federal poverty level. In 1993, 150 percent of poverty was \$17,800 for a family of three.

Medicaid is explicitly linked to cash assistance (welfare) programs and, as such, is tied to welfare reform efforts. The Medicaid program, through federal requirements, identifies mandatory, optional, and medically needy eligibility groups. To obtain federal Medicaid dollars, states must provide coverage to the mandatory eligibility group, but they have discretion in providing coverage to individuals in the optional category. Table 1 lists the mandatory and optional eligibility groups.

The "medically needy" category, based on the medically indigent concept, generally applies to individuals

who have incomes and/or assets that slightly exceed the levels allowed under either the mandatory or optional categories. These individuals may become eligible after they "spend down" their incomes (i.e., incur medical expenses that cause their incomes to drop to or below the medically needy level). If a state offers this option, individuals under age 19 and pregnant women must be covered.

Medicaid provides for a broad spectrum of acute and long-term care services, some of which are mandatory (i.e., must be offered for states to obtain federal matching

Table 1

Medicaid's mandatory and optional eligibility groups

Mandatory groups

- all AFDC recipients;
- children under age 6 and pregnant women with incomes below 133 percent of poverty; all children born after September 30, 1983 (up to age 19) at or below 100 percent of poverty;
- adoption assistance recipients and foster care recipients;
- individuals who are elderly, blind, or disabled and who are receiving Supplemental Security Income (SSI); and
- Medicare-eligible persons with incomes below 100 percent of poverty and total resources at or below twice the standards for SSI.

(Non-citizens, U.S. nationals, or legal aliens admitted for permanent residence who otherwise qualify for Medicaid are entitled to coverage for emergency medical conditions, including emergency labor and delivery).

Optional groups

- infants up to 1 year of age and pregnant women between 133 percent and 185 percent of poverty;
- elderly or disabled adults with incomes no greater than 100 percent of poverty;
- children between the ages of 18 and 21 who meet income and resource standards of AFDC but are, for some other reason, not eligible for the program;
- caretaker relatives at AFDC levels;
- institutionalized individuals at certain levels;
- recipients of home and community-based waived services;
- elderly, blind, or disabled recipients of state supplementary programs;
- TB-infected persons who meet SSI levels; and
- pregnant women for certain time periods to allow prenatal care coverage.

Table 2

Medicaid's mandatory and optional services

Mandatory services

- inpatient and outpatient hospital services;
- rural health clinic services;
- federally qualified health center services;
- lab and x-ray services;
- nursing facility services for individuals over age 21;
- early periodic screening, diagnosis, and treatment services for individuals under age 21;
- family planning services and supplies;
- physician services;
- medical and surgical services from dentists;
- home health services;
- nurse-midwife services; and
- certified pediatric and family nurse practitioner services.

Optional services

- medical or remedial care recognized by state law (e.g., care by chiropractors, podiatrists, optometrists, psychologists);
- private-duty nursing services;
- clinic services;
- dental services;
- physical and occupational therapy;
- prescription drugs;
- dentures, prosthetics, and eyeglasses;
- diagnostic, screening, preventive, and rehabilitative services;
- inpatient hospital and nursing services for individuals over 65 years of age; and
- services at intermediate care facilities for the mentally retarded.

dollars) and others that are optional. Table 2 lists the mandatory services and optional categories of services (there are 33 specific optional services). All services offered must be provided statewide; recipients must have freedom to choose a provider; and the amount, duration, and scope of services must be equal for all individuals within both the mandatory and optional groups. States may apply for federal exemption from these requirements under Section 1115 waivers (research and demonstration) or under Section 1915 waivers (freedom of choice and home and community-based services).

States have many options available in determining eligibility and defining covered services. They also have the ability, within very broad parameters, to determine reimbursement methods and rates. Consequently, the Medicaid program is different in virtually every state and reflects state-level public opinion regarding the treatment of the poorest members of society. These differences have created a situation described as "the greatest inequity of the American health-care system ... not between the non-poor and the poor, but between the insured poor and the uninsured poor."⁵

FACTS AND FIGURES

In 1993, approximately 33 million people in the nation received Medicaid benefits (about 10 percent of the U.S. population) at a total cost of about \$131 billion.² Figure 1 shows the distribution of Medicaid recipients and expenditures by eligibility category. Although low-income children represent nearly one-half of all Medicaid recipients, they account for only 16 percent of all expenditures. The disabled population (15 percent of recipients) accounts for nearly 40 percent of all expenditures.

Medicaid services are increasingly consumed by elderly and disabled beneficiaries. In 1993, expenditures for long-term care services (i.e., home health, care for the mentally retarded, and nursing facilities) accounted for nearly 40 percent of total expenditures; however, more than 85 percent of all long-term care expenditures were for institutionally based care.² Figure 2 illustrates the distribution of expenditures by type of service. Since 1975, the distribution of payments has changed as more services have been provided in home health and outpatient settings. Physicians' share of Medicaid payments actually fell from 10 percent in 1975 to about 7 percent in 1993.²

Absent a federal waiver, states are required to allow

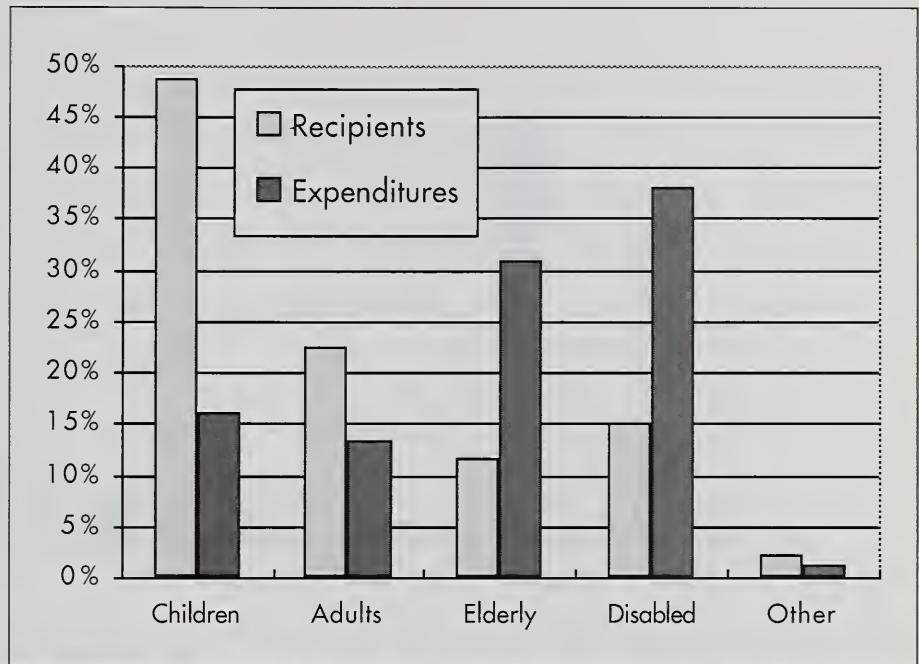


Figure 1—Distribution of Medicaid recipients and expenditures, 1993.

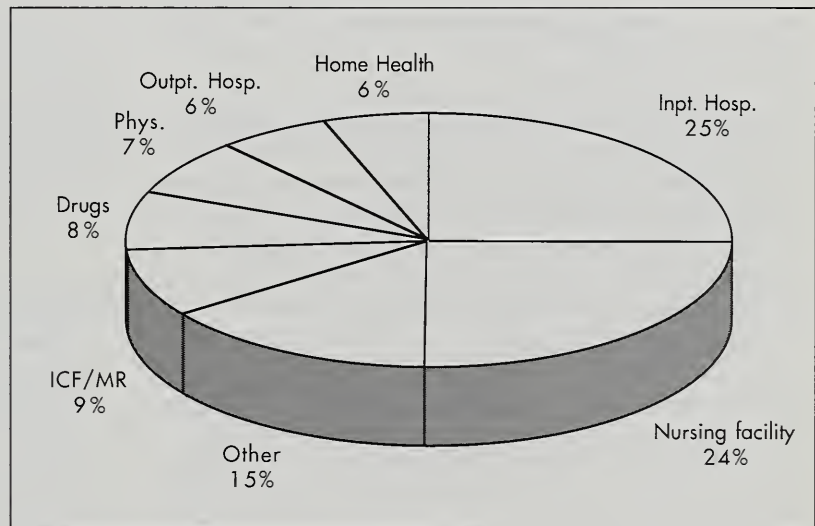


Figure 2—Distribution of Medicaid payments, 1993.

Source: Health Care Financing Review, 1995 Statistical Supplement.

Medicaid recipients the freedom to choose their provider, making fee-for-service the dominant mode of delivery and financing. However, in an effort to improve access and contain costs, states increasingly are attempting to encourage their Medicaid enrollees to choose managed care plans. Encountering resistance from enrollees, more and more states are obtaining Section 1115 waivers to implement mandatory managed care projects for all beneficiaries. As of June 1994, about 8 million Medicaid beneficiaries (or 25 percent) were enrolled in managed care, nearly a threefold increase since 1991.³ Although access to care is generally improved under managed care arrangements, a study that focused on the experiences of Florida and New York revealed that managed care programs did not always offer cost savings.⁶

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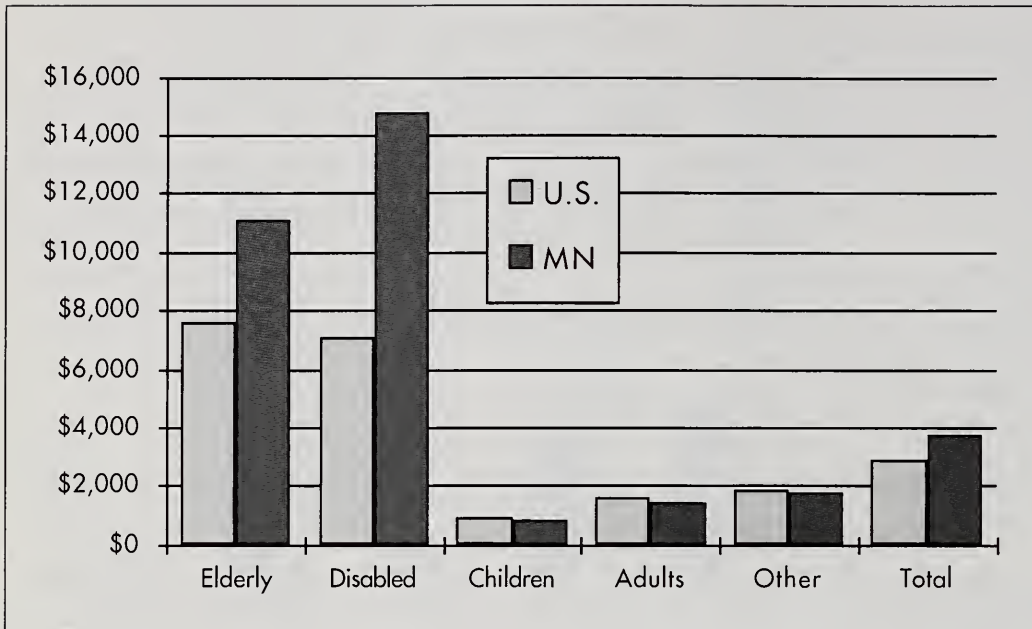


Figure 3—Minnesota (1993) and national (1991) Medicaid payments per recipient by eligibility category. Source: Minnesota Department of Human Services, 1993; HCFA, 1991.

MEDICAID IN MINNESOTA: MEDICAL ASSISTANCE

Medical Assistance, Minnesota's Medicaid program, covers acute, chronic, and long-term health care services. In 1995, estimated program expenditures totaled about \$2.8 billion, approximately \$1.5 billion of which was received from the federal government through its 54.27 percent financial participation. The remaining \$1.1 billion was generated from general state revenues.

State funding represents nearly 20 percent of the state's total budget. A recent report by former Minnesota Congressmen Sen. John Brandl and Rep. Vin Weber, "An Agenda for Reform—Competition, Community, Concentration," outlined proposals for state restructuring in the face of a projected \$8 billion state cumulative fiscal gap by 2001.⁷ Brandl and Weber noted that state health care spending is a significant problem; for example, overall state spending is projected to increase at a rate of 8.4 percent in 1998-99 and 10.1 percent in 2000-01. Health care spending, however, is expected to grow by 23 percent in 1998-99 and again in 2000-01. By comparison, higher education spending is projected to increase 0.8 percent and 6.9 percent during the same years. The potential for reduced federal dollars and the resulting strain on the state budget may require a major change in the state's Medicaid program.

State Medical Assistance payments, like health care payments in the general population and the national Medicaid program, are disproportionately consumed by a small percentage of individuals. The low-income elderly and disabled population (about 23 percent of state program recipients) consume about 70 percent of program expenditures. Figure 3 shows Minnesota and national Medicaid payments per recipient by eligibility category. It is apparent that coverage for the elderly and

disabled is driving the program costs; payments for disabled persons are more than twice the national average, and payments for the elderly are 1.5 times the national average.

The Medical Assistance program provides coverage for all mandatory health care services and for 31 of the 33 optional services.[‡] For all services, the Medical Assistance program served about 430,000 individuals in 1994. By 1997, Medical Assistance eligibility is expected to approach 470,000. The program operates six home- and community-based waivers (1915[c]) and one freedom-of-choice waiver

(1915[b]). The state also recently obtained a waiver to implement the Long Term Care Options Project, a program to integrate long-term care and acute-care services under combined Medicare and Medicaid capitation payments for Medicare recipients who are on Medicaid.

PREPAID MEDICAL ASSISTANCE PROGRAM

As early as 1975, Minnesota had contracts with prepaid health plans for the voluntary enrollment of Medicaid recipients. In 1982, Minnesota became one of five states selected by the Health Care Financing Administration to participate in a Section 1115 waiver demonstration project to test alternative health care financing and delivery systems. Minnesota's proposal, the Prepaid Medical Assistance Program, or PMAP, required mandatory enrollment[§] in a capitated prepaid health plan for the Medical Assistance population to be tested in one

‡The services not covered are Christian Science nurses' services and respiratory care services (respiratory care is covered, but under a different category).

§Medical Assistance recipients are excluded from PMAP participation if they are Medicaid eligible through a spend down; receive personal care attendant services; live in a state institution; receive Refugee Assistance benefits; are MA eligible through adoption subsidy; are under age 65 and are blind or are certified disabled by Social Security; have private HMO coverage; are residents of Itasca County but use Cass Lake, Hibbing, or Red Lake providers; are Qualified Medicare Beneficiaries and not otherwise MA eligible; are terminally ill; are in foster placement; are children in need of protective services; are children diagnosed as SED receiving county MH case management and primary MH services prior to enrollment in PMAP; or have a communicable disease for which the prognosis is terminal and a primary physician certifies that disruption of the physician-patient relationship would be harmful.

rural, one suburban, and one urban county. During 1985 and 1986, PMAP was implemented in Itasca, Dakota, and Hennepin counties. Authority for PMAP was limited to a three-year demonstration project, but congressional action extended its scope and duration through June 30, 1996. In 1993, Ramsey County's enrollees were included in PMAP, and Anoka, Carver, Scott, and Washington counties were added in 1994. Currently, about 140,000 Medicaid enrollees receive their care through PMAP. As part of a broad federal waiver approved in 1995, Minnesota has authority to continue and expand PMAP statewide through June 30, 2000. Effective January 1996, eight additional counties have been added to PMAP—Koochiching, Carlton, St. Louis, Cook, Lake, Stearns, Benton, and Sherburne. Medical Assistance enrollees will begin conversion to a prepaid plan during February 1996. The Department of Human Services expects to convert all other counties to PMAP by mid-1997.

OTHER STATE-SUBSIDIZED PROGRAMS

In addition to the Medicaid program, Minnesota operates two other publicly subsidized health care programs, General Assistance Medical Care (GAMC) and MinnesotaCare.

GAMC

GAMC is a state-funded program that provides coverage for acute health care services; long-term care services are not covered. The program was created in 1973 and currently serves about 53,000 Minnesota residents (about 25 percent of whom currently receive services through managed care).

Individuals eligible for the program are generally state residents who do not meet the categorical requirements for Medical Assistance but who do meet the "medically needy" income and asset requirements under Medical Assistance (about 65 percent of poverty). Generally, this includes parents in families that do not meet AFDC requirements, people who are not over age 65 or not disabled, and individuals who are residents of institutions for mental diseases and who would otherwise be eligible for Medicaid. In 1995, estimated expenditures for GAMC services totaled about \$196 million.

MINNESOTACARE

MinnesotaCare is a state-funded program that in 1995 provided coverage for acute-care services (inpatient hospital coverage is limited to \$10,000 per year for adults) for about 79,000 previously uninsured persons at a cost of about \$64 million. The majority of MinnesotaCare enrollees live outside the Twin Cities metropolitan area. The program was developed in 1991 as the successor to the Children's Health Plan and has provided coverage to more than 90,000 people since 1992. Eligibility is based on family income (assets are excluded) and is set at 275 percent of poverty for families with children. Eligibility was expanded in October 1994 to cover individuals and families without children up to 125 percent of poverty. Table 3 summarizes MinnesotaCare eligibility.

The MinnesotaCare program is financed through

Table 3

MinnesotaCare eligibility

Minnesota residency

- Children under age 21 and their families must demonstrate intent to make Minnesota their home;
- Pregnant women must demonstrate intent to make Minnesota their home;
- Non-pregnant adults must have lived in Minnesota at least 180 days prior to applying, must intend to make Minnesota their home, cannot have moved to the state for the purpose of obtaining medical care, and must have a permanent address.

Lack of other health coverage (this is intended to minimize the erosion of private health care coverage):

- Applicants cannot have had other health insurance for the four months prior to application (this includes Medicare but does not include Medical Assistance or Children's Health Plan).

Limited access to employer-subsidized insurance (18-month rule):

- Applicants cannot currently have access to employer-subsidized insurance (insurance offered by an employer for which the employer pays at least 50 percent of the premium) or have had access to employer-subsidized insurance for the past 18 months. (Past access does not apply to children under age 21. The rule does not apply to the following: dependents who lost coverage because of divorce or death of policyholder, persons laid off from jobs, 21- to 25-year-olds coming off a parent's health insurance policy, and persons leaving the military who were covered by CHAMPUS.)

Income (gross household income, earned and unearned, before taxes and deductions):

- Families, pregnant women, and children under age 21: 275 percent of federal poverty guideline (under a federal waiver received in 1995, pregnant women and children in the MinnesotaCare program actually receive full Medical Assistance benefits and federal Medicaid funds);
- Children in families below 150 percent of federal poverty guideline eligible without satisfying four-month uninsured and 18-month no access to employer subsidized insurance requirements; and
- Single adults (over age 21) and households without children: 125 percent of federal poverty guideline.

revenue dedicated to the Health Care Access Fund. Revenue in this fund is principally generated from a 2 percent tax on the gross revenues of hospitals and providers (including physicians) and a 1 percent premium tax on HMOs and nonprofit health service plan

corporations (e.g., Blue Cross/Blue Shield, Delta Dental). Revenue is also generated through premiums paid by enrollees on a sliding scale basis.

THE ROLE OF CONGRESS

Congress' proposal for reforming the Medicaid program, as delivered to President Clinton, included a reduction in projected spending of \$133 billion over seven years. The proposal also called for a fundamental policy shift in the treatment of health care coverage for the poor. Although President Clinton vetoed the proposal, a brief discussion of Congress' intent sheds light on the continuing rift between the president and the congressional Republicans.

The congressional proposal called for the repeal of the existing Medicaid law in favor of a new Title XXI of the Social Security Act—MediGrants. The most fundamental change proposed was the elimination of the individual entitlement nature of the program. Instead, MediGrants would effectively put the federal portion of a previous year's expenditures in block grants that states would administer in accordance with "maintenance of effort" requirements (i.e., continued percentage of previous funding for particular groups of individuals). The proposal called for a growth rate for Minnesota of about 2 percent, down from the current 10 percent annual growth rate, meaning the state would lose an estimated \$2 billion in federal money over the seven years. Many Republican governors, including Gov. Arne Carlson, supported early versions of the plan, even at a 2 percent growth rate, provided states were given complete flexibility in administering the program.

In sharp contrast to the Republican proposal, President Clinton is proposing the development of a per-capita cap plan that is expected to reduce expected expenditures by about \$54 billion over seven years. The proposal would limit increases in federal spending on each Medicaid recipient to about 6.1 percent per person per year, approximately 1 percent below projected private-sector medical inflation.⁸ The primary policy difference between the per-capita cap proposal and a block grant proposal is that under Clinton's plan, Medicaid would remain an entitlement program, and, as opposed to block grants, his plan would guarantee a state more federal money if its low-income population grew. To help states manage fewer federal dollars, Clinton also has proposed greater state flexibility in service delivery through managed care (without the need for federal waivers) and a relaxation of some federal regulations. Consensus on a Medicaid proposal appears more difficult than consensus on Medicare. Given the deep philosophical differences, a long and difficult debate seems certain.

Congressional interest in the Medicaid program has spawned state efforts to reduce program growth. In 1995, Minnesota received federal waiver authority to expand managed care and integrate Medicaid with the state's other two publicly subsidized health care programs (GAMC and MinnesotaCare). Although congressional action will certainly affect Minnesota's Medicaid

program, the state is prepared to forge ahead with its plans with or without a federal block grant.

Task Force on Medical Assistance

See this month's *Monitor*, page 35, for a summary report from the Minnesota Medical Association's Ad Hoc Task Force on Medical Assistance.

CONCLUSION

Escalating costs and philosophical questions about the role of government in health care delivery have increased the pressure for Medicaid reform. Yet, despite its shortcomings,

Medicaid has improved access to health care for the nation's poor, has become the primary source of payment for medical care for AIDS patients, has spurred the development of alternative systems for long-term care services, and has assisted in the development of new methods for caring for people who suffer from mental and physical disabilities.^{3,4} As noted by John Iglehart, founding editor of *Health Affairs*, how policymakers address Medicaid "will be a measure of our society's willingness to improve the medical care made available to people whose means and choices are limited."⁴ MM

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REFERENCES

1. Rowland D. Medicaid at 30: new challenges for the nation's health safety net. *JAMA* 1995;274(3):271-3.
2. Health Care Financing Administration. Medicare and Medicaid statistical supplement. *Health Care Financ Rev* 1995;16(supl):118-55.
3. Kaiser Commission on the Future of Medicaid. Medicaid facts. Washington, D.C.: Kaiser Family Foundation, February 1995.
4. Iglehart J. Health policy report: the American health care system—Medicaid. *N Engl J Med* 1993;328(12):896-900.
5. Joe T, Meltzer J, Yu P. Arbitrary access to care: the case for reforming Medicaid. *Health Aff* 1985;4(1):59-74.
6. Buchanan J, Leibowitz A, Keesey J, Mann J, Damberg C. Cost and use of capitated medical services: evaluation of the program for prepaid managed care. Santa Monica, California: RAND Corp., 1992.
7. Brandl J, Weber V. An agenda for reform: competition, community, concentration. A report to Governor Arne H. Carlson. November 1995.
8. Bureau of National Affairs. Health care policy report: Clinton plan would keep entitlement, give states 'unprecedented flexibility.' Washington, D.C.: Bureau of National Affairs, 4 December 1995.



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People and Places Making Medical News

People

BMP Appoints Executive Director

Robert A. Leach has replaced H. Leonard Boche as executive director of the Minnesota Board of Medical Practice. Leach has been a BMP staff member since 1988 and has supervised its complaint review unit for the last three years.

Health Commissioner Resigns

Carolyn McKay, M.D., resigned as health commissioner of the Minneapolis Health Department effective January 5 after four years at the post. Del Hurt, director of administration, is serving as acting commissioner. Minneapolis Mayor Sharon Sayles Belton, who accepted McKay's resignation, is considering whether to eliminate the commissioner position as part of a health department reorganization.

While McKay was commissioner, the infant mortality rate in Minneapolis dropped to a 10-year low and more pregnant women now seek prenatal care, said Sayles Belton in a *St. Paul Pioneer Press* article. McKay plans to return to full-time clinical practice.

'U' Appoints Surgery Chief

David Dunn, M.D., has been appointed head of the University of Minnesota Medical School's Department of Surgery following a nationwide search. Dunn, who served as interim department head since May, succeeds John Najarian, M.D., who resigned in February 1993.

A 1977 graduate of the University of Michigan Medical School, Dunn is an internationally known authority on surgical infectious diseases, transplantation, general

surgery, and surgical education. After completing his residency in general surgery and his doctorate in microbiology at the University of Minnesota in 1985, he joined the Department of Surgery faculty in 1986.

During his tenure as head of the surgery department's division of surgical infectious diseases, Dunn developed one of the nation's leading clinical, research, and training programs in that area. He also directs the Surgery Department's graduate studies and residency programs.

Physician of Excellence Award

Allan C. Kind, M.D., an infectious disease specialist at Park Nicollet Clinic HealthSystem Minnesota, received the 1995 Earl G. Young Physician of Excellence award presented annually by the medical staff of Methodist Hospital HealthSystem Minnesota. Kind's colleagues nominated him for his dedication to patient care, his support of professional and community health education, and his outstanding leadership as a former chief of staff and member of the educational affairs committee at Methodist Hospital.

Kind joined Park Nicollet Medical Center in 1969 and was a member of the clinic's board of trustees from 1982 through 1988. Since 1989 he has been vice president of education for Park Nicollet Medical Foundation, now called the Institute for Research and Education HealthSystem Minnesota. He was vice president of the Minnesota branch of the American College of Physicians from 1987 to 1991, and he served as president of the Minnesota Society of Internal Medicine in 1985. He has been a member of the education committee of the Minnesota Medical Association since 1988.

Kind co-authored and co-edited "Take Charge of Your Health," a home medical reference published by the Health Education Department of the Institute for Research and Education HealthSystem Minnesota. He heads a program that provides health education to teachers in the west-metro area, and he is developing an on-line medical education program for youth.

Physicians Join Abbott's Clinic 42

Frank Rhame, M.D., and Rocco Russo, M.D., have joined the staff of Abbott Northwestern's Clinic 42, an HIV/AIDS and infectious disease clinic, and The Doctors, a primary care clinic in the Uptown area of Minneapolis.

Rhame, who practiced at the University of Minnesota for 16 years, will see patients three to four days a week in Clinic 42 and The Doctors. He continues to serve as medical director of the University of Minnesota infection control program and consultant for the statistical center of the community program for clinical research on AIDS.

Russo, who previously was in private practice and worked with the Kaiser Permanente Medical Group in southern California, will see patients one to two days a week at Clinic 42 and will spend the rest of the week at The Doctors.

CDI Hires Vice President

The Center for Diagnostic Imaging (CDI) has hired David W. Shoemaker Jr., M.D., to serve as vice president. In addition to his subspecialty spine interpretative services, Shoemaker will focus on developing business partnerships and strategic alliances and will

continue to develop CDI's tele-radiology practice and expand nuclear medicine services.

Previously, Shoemaker was a radiologist in the Columbia Gorge region of Oregon, where he was president of the Columbia Gorge Independent Practice Association. He also has served as medical director of the Western New York MRI in Buffalo, New York.

CDI, based in Minneapolis, operates seven radiologic imaging centers and is licensed to provide services through contracts in 24 states.

Starbuck Awards

Robert Bösl, M.D., of Starbuck, Minnesota, received the first Rural Physician Associate Program Preceptor Achievement Award from the University of Minnesota's Rural Physician Associate Program (RPAP). The award, sponsored by Searle, recognizes a preceptor for outstanding medical student teaching and mentoring.

Robert McDonald received the seventh annual RPAP Student Achievement Award sponsored by the Upjohn Company. The award recognizes a student for community involvement and academic accomplishment. Bösl nominated McDonald for his dedication to patient care, his involvement in community affairs, and his charity work as a member of the Starbuck Lions.

P l a c e s
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BCBSM and HealthSystem Minnesota Put Nurses 'On Call'

Blue Cross and Blue Shield of Minnesota (BCBSM) and HealthSystem Minnesota plan to offer consumers both locally and nationally another option to obtain care for routine medical situations. Care on Callsm, the new service, provides treatment over the phone for routine medical problems, 24 hours a day, seven days a week.

At the first sign of illness, participating plan members are

encouraged to call the service to talk with a registered nurse specially trained to answer callers' questions, assess individual medical conditions using physician-approved guidelines, and recommend appropriate care. Once a diagnosis is made, nurses help patients determine whether their condition warrants a clinic visit, a trip to urgent care or the emergency room, or home management. Following the physician-approved guidelines, nurses also can call in prescriptions for certain routine medical conditions, such as urinary tract infections or conjunctivitis, and may also schedule an appointment with the patient's health care provider. A record of the patient's condition and any recommendations made by a Care on Call nurse are forwarded to the caller's primary care provider. If a caller decides to care for the condition at home, a nurse calls the patient back to follow up on his or her condition. The cost of a Care on Call contact is \$12 to \$15.

Nurses staffing the service currently field about 400 calls a day. Park Nicollet Clinic plans to expand phone coverage to all 18 of its sites.

S o c i o e c o n o m i c s
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Mankato Hospital and Mayo Unite

Mankato's Immanuel-St. Joseph's Hospital Corp. has agreed to become part of the Mayo Health System. The affiliation is expected to be completed by March 1.

Historically, Mayo has attracted Mankato residents to its Rochester site. There are no immediate plans to establish Mayo clinics in the Mankato area, but such a proposal will be seriously considered, said Michael Wood, M.D., an orthopedic surgeon and member of Mayo's negotiating team. "Our research shows a need for more family physicians in the region. We will work closely with regional

physicians to explore the possibility of establishing a network of primary care clinics in communities outside Mankato, but inside the area served by Immanuel-St. Joseph's Hospital," he said.

Under the plan, the hospital will be governed by a new 15-member board, with most members residing in the Mankato area. A Mayo physician will join the hospital as president and will work and reside in Mankato. Jerome Crest will continue to serve as administrator.

Mayo Health System has clinics and hospitals in Minnesota, Wisconsin, and Iowa. Its affiliated clinics in Minnesota are in Wabasha, Fairmont, Albert Lee, and Austin.

Better Medical, Social Service Ties Can Reduce Infant Deaths

Treating patients with respect, hiring translators, and referring mothers for mental health treatment can help decrease infant mortality, according to a study conducted by the Minneapolis Department of Health and Family Support and St. Paul Public Health. While the death rate for babies in Minnesota has dropped, the study found potential for further decreases through better communication and more sensitive care by doctors, hospitals, and parents.

Through interviews and statistical reviews, researchers examined the circumstances of infant deaths in the Twin Cities. Results show that in 1993, death rates were higher among infants born to black and American Indian mothers than among infants born to white and Asian-American mothers.

After reviewing 66 deaths that occurred in the Twin Cities, researchers said 46 percent were preventable or possibly preventable. They said that referrals of new mothers for visits by public health nurses, referrals to chemical abuse and mental health treatment, and referrals to child protection

services were not made when they should have been. Many opportunities for intervention were missed because officials had no good way to track mothers after their first contact with the medical system or social service agency. In light of this, health officials recommend better links between the health care and social service systems. They suggest providing translators, better follow-up care after birth, and communication that is respectful, comfortable, and culturally appropriate.

MinnesotaCare Helps Reduce Welfare Load

A statistical model shows MinnesotaCare has helped reduce welfare caseloads, according to state officials quoted in a January Twin Cities *Star Tribune* article. According to statistical models, MinnesotaCare, which now provides medical insurance to 95,000 low-income Minnesotans, has kept 4,100 families off welfare and results in a net savings of \$2 million a month to the state and federal government.

Department of Human Services officials believe that health care and child care benefits make the transition back to work more likely for welfare recipients. "There is a direct correlation between offering people a way off welfare and having them get off welfare," said John Petraborg, deputy commissioner of Human Services.

No Big Rate Increases for Medicare HMO Enrollees in '96

Seniors participating in health maintenance organizations (HMO) for Medicare coverage will not see any significant changes in their 1996 premiums, and several enrollees may even see a decrease.

Group Health and Blue Plus have reduced their 1996 rates for basic Medicare HMO plans, resulting in annual premium

savings of \$30 to \$47 in Hennepin and Ramsey counties. Higher prescription costs have led Blue Plus to raise its nonbasic HMO premium by \$7 to \$8 per month. Group Health's premium will remain the same. Medica, whose rates have remained steady for the last three years, has increased its rates 3 percent to 5 percent for 1996, which means a \$36 annual increase for its Medicare HMO plans.

Metropolitan HMO Markets Growing

The number of metropolitan markets served by HMOs rose 11.4 percent from mid-1994 to January 1995, according to "The Competitive Edge Regional Market Analysis 5.2," an InterStudy report focusing on the U.S. metropolitan markets in which HMOs operate.

As of January 1995, metropolitan HMO enrollment represented 91 percent of the nation's total HMO enrollment, with 46.2 million enrollees residing in metropolitan areas. The top five large consolidated markets ranked by 1994 enrollment gains were Los Angeles-Riverside-Orange County, New York-Northern New Jersey-Long Island, Washington-Baltimore, Houston-Galveston-Brazoria, and Boston-Brockton-Nashua. Average penetration rates were 25 percent in large markets, 17.6 percent in medium markets, and 12 percent in small markets.

Rates, Trends, Data

Infant Deaths, Divorce, and Abortion Down in Minnesota

The death rate for infants dropped to a record low of 7.0 per 1,000 live births from 7.5 in 1993, according to an annual report from the Center for Health Statistics at the Minnesota Department of Health. Although the change is not statistically significant, it does keep Minnesota's rate lower than the U.S. rate of 7.9 for 1994.

Divorce fell to the lowest level since 1986, declining 1.7 percent from 16,025 in 1993 to 15,746 in 1994. The state's divorce rate, 3.4 per 1,000 population, is lower than the national rate of 4.6.

The number of reported abortions fell 2 percent, from 12,955 in 1993 to 12,702 in 1994. Births totalled 64,277 in 1994, a slight drop from 64,646 in 1993.

The health department also reports that although heart disease has decreased significantly in the past decade, it remains the leading cause of death in Minnesota, responsible for 10,241 deaths in 1994. Cancer and stroke are the state's other top killers. Cancer caused 8,542 deaths and stroke 2,896 in 1994.

ED Reports of Drug Use Up

Reports of marijuana and cocaine use by patients admitted to Twin Cities emergency departments increased drastically in 1994, according to a survey from the state Department of Human Services. The ED reports are believed to reflect changes in drug activity in the community.

Reports of cocaine use, mostly crack cocaine, increased 34 percent, ending a pattern of level use for the past three years. But the reported increase in marijuana use may be more noteworthy, said survey author Carol Falkowski in a Twin Cities *Star Tribune* article. "We've had more treatment admissions this year (1995) for marijuana than for coke and more than half of the marijuana admissions were people 17 or younger," she said.

Both Minnesota and national reports indicate that use of higher-purity, more potent marijuana is increasing. Reports of methamphetamine use and treatment admission for their abuse also rose in 1994.

Law & Policy

Commission Increases Penalty for Domestic Assault

The Minnesota Sentencing Guidelines Commission has voted to increase the felony ranking for third-time domestic assault from its originally recommended level one to a level four. One is the lowest score on the commission's 10-point severity scale.

Minnesota sentencing guidelines recommend prison terms based on the severity of a defendant's crime. A ranking of four puts third-time domestic assault on par with third-degree assault. Critics had argued that a ranking of one, which applies to such crimes as check forgery under \$200, would have sent the wrong message to offenders. Deputy Hennepin County Attorney Patrick Diamond had urged the commission to raise the domestic assault felony to a level six, which includes kidnapping and aggravated robbery.

Medical Assistance Must Fund Some Abortions

The Minnesota Supreme Court has ruled that Medical Assistance must pay for therapeutic abortions because the state program funds childbirth-related health services. The ruling affirms a lower court's decision to strike down a 16-year-old law that prevented use of public money for abortions except to save a pregnant woman's life or in cases of rape or incest that had been reported to police.

"A similar constitutional challenge would certainly arise if the Minnesota Legislature funded abortions for qualified women to limit the population of the poor, but refused to provide medical care for poor women who choose childbirth," stated the decision, written by Chief Justice A.M. "Sandy" Keith. "Thus, the constitutional issues in this case concern the protection of *either* choice from

discriminatory governmental treatment."

The court stated that the ruling will not permit any woman eligible for Medical Assistance to obtain an abortion "on demand," but will instead leave the decision to the woman and her doctor.

Innovations

New Device Treats Patients With Inoperable Aneurysms

Abbott Northwestern Hospital in Minneapolis is one of 40 U.S. centers approved to use the Guglielmi Detachable Coil (GDC) for treating patients with intracranial aneurysms that are considered either inoperable or very high risk for surgery. It is the first medical device the FDA has approved for treating these patients.

The GDC is a soft platinum alloy micro-coil that is delivered into the aneurysm site by a micro-catheter. The micro-catheter/guidewire system is inserted in the femoral artery then threaded through the vasculature of the body into the cerebral vessels. The coil is detached and released into the aneurysm by application of a very low voltage electrical current. Once in place, the GDC coil fills the aneurysm, isolating it from circulation and thereby reducing the likelihood of a rupture and hemorrhage.

Clinical trials have shown that in individuals who have suffered a subarachnoid hemorrhage, this treatment dramatically reduces the likelihood that they will suffer a second hemorrhage, an event associated with a mortality rate of more than 50 percent.

"The GDC is the best option for patients with inoperable or surgically high-risk aneurysms, who risk hemorrhage due to aneurysmal ruptures," said David Tubman, M.D., a neuroradiologist

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Medical Research

Leukemia in Infants Linked to Mother's Alcohol Consumption

An infant's risk for leukemia appears to increase if a mother drinks even moderate amounts of alcohol during the last six months of pregnancy, according to an international research team headed by Xiao-Ou Shu, M.D., Ph.D., of the University of Minnesota.

Researchers found that a pregnant woman's consumption of alcohol is associated with a 10-fold increase in her infant's risk of developing acute myeloid leukemia and a 2.3-fold increase in the risk of developing acute lymphoid leukemia. The findings do not prove that alcohol consumption can promote development of

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leukemia, but the study does suggest a cause and effect relationship, said Shu, who is chief author of the report, published in the January 2 *Journal of the National Cancer Institute*.

The study included 302 infants whose leukemia was diagnosed before age 18 months and 558 randomly selected infants and their families. Parents in both groups were asked about their smoking and drinking histories, as well as exposures to other health risks.

The highest risk was among infants whose mothers consumed more than four drinks a month during the last two trimesters of pregnancy. The risk to infants also appeared to be slightly higher if a father smoked during the month before conception than if the father didn't smoke at all. The study showed no increased risk if the mother smoked or if the father drank before pregnancy.

Taxol May Increase Survival for Ovarian Cancer Patients

Chemotherapy treatment with Taxol may significantly extend the lives of women with advanced ovarian cancer, according to a report in the January 4 *New England Journal of Medicine*.

Researchers at 39 U.S. institutions, including the University of Minnesota, randomly assigned 400 ovarian cancer patients to the new treatment with cisplatin and Taxol or to the standard therapy with cisplatin and cyclophosphamide. The drug showed benefit in 51 percent of the women receiving Taxol therapy, compared with only 31 percent of the women receiving standard therapy. Survival figures are incomplete because many women are still alive, but average survivals thus far are 24 months for those who underwent standard therapy and 39 months for those whose therapy included Taxol.

Chronic Illness Linked to Eating Disorders

Teenagers who have a chronic illness, such as asthma, attention deficit disorder, or diabetes, have an increased likelihood of developing an eating disorder, according to a University of Minnesota study published in the December issue of the American Medical Association's *Archives of Pediatrics and Adolescent Medicine*.

Researchers were surprised to discover the trend in a study involving 36,284 students from across the state in grades seven through 12 during the 1986-87 school year. They found, for example, that while 8.5 percent of adolescent girls with no chronic illnesses said they induce vomiting, nearly 15.5 percent of the girls with asthma and 19.1 percent with attention deficit disorder (ADD) reported intentionally purging. Only 3.8 percent of the boys with no chronic illnesses reported that they self-induce vomiting, while 6.2 percent of those with asthma and 11.2 percent of those with ADD said they engage in the practice.

Robert Blum, M.D., a pedi-

rics professor and director of the Division of General Pediatrics and Adolescent Health at the university, said parents, teachers, school nurses, and doctors should pay more attention to the overall well-being of adolescents who have chronic illnesses.

Chromosome Abnormalities Found Among Pesticide Workers

Chromosomal abnormalities that may signal an increased risk of non-Hodgkin lymphoma have been found among farm pesticide applicators, report University of Minnesota researchers in the January/February issue of *Cancer Epidemiology, Biomarkers and Prevention*. In a study of 61 pesticide applicators in Minnesota and 33 unexposed control subjects, the researchers found various breaks on chromosomes 14 and 18 among the pesticide applicators. The study subjects included 20 individuals who applied herbicides, 18 who worked with insecticides, and 23 who applied fumigants.

Abnormalities on these chromosomes have been linked in previous studies to an increased risk of non-Hodgkin lymphoma, which affects more than 7,000 Americans every year. Specifically, 11 breaks and rearrangements of defined areas of chromosome 14 were found among nine of the fumigant applicators, and nine similar abnormalities were found on chromosome 18 among six herbicide workers. No non-Hodgkin lymphoma-related abnormalities of chromosome 14 and 18 were found among the control subjects.

"The work we have done shows that pesticide applicators can undergo temporary chromosome damage at sites that can be associated with certain cancer and birth defect risk," said Vincent Garry, M.D., professor of laboratory medicine and pathology and the study's principal investigator. "Whether the findings truly extend to long-term health effects needs thorough examination." **MM**

HUMPHREY

(continued from page 7)

agency rooms, and it's difficult to argue with that perspective."

Working together along these lines, Humphrey believes the group can sidestep sticky constitutional issues and help staunch the flood of media violence. "If corporations are unwilling to buy advertising for violent programs, then these programs will drop from the airwaves," he says.

Children's Advocate

Bringing innovative programs to Minnesota youth

As any physician knows, healthy living habits developed early in life can prevent subsequent health problems. Prevention is key to many of the attorney general's efforts and accounts for his emphasis on programs directed at young people. As chair of the Drug Abuse Resistance Education (D.A.R.E.) program in Minnesota and founder of the Partnership for a Drug-Free Minnesota, Humphrey brings anti-drug and anti-violence messages to thousands of Minnesota students.

In addition, the attorney general's office sponsored a Youth Summit in January at the state Capitol with the Minnesota Medical Association and the University of Minnesota's Minnesota Center for Community Legal Education of the Center for 4-H Youth Development. The summit brings together high school students from all over Minnesota to testify on proposed anti-violence bills before the Legislature. The purpose: to give young people the opportunity to help reduce violence while they learn about the legislative process. (See related article, page 8.)

Last year, the summit's attendees looked at juvenile justice issues—and according to Humphrey, many of their recommendations were incorporated into legislation now in place. This year, the focus is on gun violence. The students debated a bill proposed by the MMA on safe gun storage. In its current form, the bill

would make it a gross misdemeanor to store any firearm unless it's unloaded and locked up when a child is present in the home. According to the MMA, limiting access to unlocked, usable firearms would reduce teen suicides, accidental shoot-

ings (children playing with guns), gun-related violence, and "fit-of-rage" shootings.

Humphrey's office is supporting and helping develop the legislation. "I love hunting and the sporting use of guns, but I think we have to face

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the fact that these tools, when mislaid and misused, all too often become the means by which terrible violence occurs," he says. "Again, I congratulate the MMA on their willingness to not only speak out on the issue of gun violence, but to offer a practical solution."

Consumer Protector

Taking on the tobacco industry

Humphrey and his office are challenging the tobacco industry. In a lawsuit filed last year, Minnesota became the first state to take on the industry for violating consumer fraud and antitrust laws. "The consumer fraud laws say companies cannot knowingly lie about their products, and the antitrust laws say companies cannot conspire with competitors to manipulate the free market to their advantage," explains Humphrey. "Recently disclosed evidence indicates what many have long suspected: the tobacco industry has been violating these laws for decades."

The case is currently in the discovery phase, during which literally boxes of evidence are being collected, consolidated, and organized. Humphrey expects this process to take another year, then the actual trial should begin.

"The industry considers this suit a *very serious threat*," says Humphrey. "Consequently, they are applying all the resources they have, and believe me, they have *unlimited* resources. We're fortunate to have some of the most expert litigators with us. We have a good case, but it's one that will take awhile." (For more on the attorney general's lawsuit, see "Industry Under Fire: Minnesota v. the Tobacco Industry," in the April 1995 issue of *Minnesota Medicine*, page 23.)

Humphrey also is championing tough state laws to enforce the ban on selling tobacco to minors. Before St. Paul passed an ordinance to enforce such laws, 80 percent of minors attempting to purchase tobacco products were able to do so. A subsequent check after the enforcement ordinance was in place showed that the number had dropped to just 8 percent. "We're pleased to report that these laws work very well," says Humphrey.

Enforcing antitrust laws

The attorney general's efforts to support consumers by enforcing antitrust and collusion laws extend beyond the tobacco industry, and continuing mergers by managed care organizations in the Twin Cities have brought the health care business under Humphrey's scrutiny. "In this country, we believe that competition in an open marketplace is the way we should do commercial business," he says. "In our role as enforcers of [antitrust] law, we look at areas of concentration—and the managed care market is such an area. We try to determine whether further concentrations will reduce competition to the point where patients/consumers no longer effectively have any choice. If so, there may be a violation of antitrust laws."

Humphrey likens his office's position vis-à-vis the health care industry to that of the relationship be-

tween the U.S. Department of Commerce and the banking industry. "Though the DOC regulates and investigates the banking industry, it also plays a major role in helping the industry by ensuring, through such regulation, a high level of confidence in our banks," he says. Similarly, the attorney general's office enhances consumer confidence in the medical profession.

Given the dynamics and complexity of the health care industry today, Humphrey says he must consider each case on its own merit—whether it's a new arrangement between Allina and HealthEast, for example, or cooperation among smaller medical practices. "In some cases, we've found that although there was an impact from concentration, because it didn't preclude other reasonable choices for the public, we took no action. In others cases, however, organizations had joined together to maintain high charges or exclude other participants and payment systems from using the services. These are illegal actions, and we treated them as such."

Although the relationship between the MMA and the attorney general has occasionally been adversarial, Minnesota's chief lawmaker primarily views the MMA as a valued partner. "The MMA has become a dynamic force in increasing public awareness of some very complex issues—ones which all too often those in public office ignore or avoid because of their divisiveness and political volatility. The MMA has been able to say, 'we know there are divergent views here, but we also know what we are seeing in our emergency rooms and clinics. It's time to do something about this.' By working together to achieve common goals, we support and add credibility to one another's efforts—ultimately to the benefit of all Minnesotans." **MM**

Joseph Moriarity is a free-lance writer residing in Marine on St. Croix, Minnesota.



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Dodge Grand Caravan LE	\$27,880	\$25,555	\$462	\$403	\$370	\$337
Toyota Corolla 4Dr DX	\$18,210	\$16,288	\$279	\$246	\$264	\$244
Ford Explorer XLT 4Dr 4WD	\$28,835	\$26,200	\$415	\$380	\$356	\$327
Honda Civic 4Dr LX	\$16,230	\$14,955	\$258	\$226	\$208	\$211
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(continued from page 13)

ensuring access to health care services in rural areas. Since many local employers are self-funded, providers want to serve them without an insurance carrier in the middle.

A CATCH-22

In effect, the provider cooperative law creates a Catch-22. Providers form cooperatives so they can deal directly with purchasers and bypass insurers and HMOs. The law requires the cooperative to have payment arrangements that are capitated or involve significant risk-sharing. But in the view of insurance regulators, taking risk means you're in the insurance business and subject to regulation. The National Association of Insurance Commissioners (NAIC) has taken the position that capitated provider networks can be exempted from state insurance regulation only if they are accepting "downstream risk"; that is, the provider agrees to assume all or part of the risk for health care expenses or service delivery under a contract with a licensed health insurer. Under that arrangement, consumers and providers can go back to the insurer if they have claims for services or payment.

In 1995, the hospitals went back to the Legislature and got approval for a demonstration project in which one provider cooperative in south-central Minnesota (the Quality Health Alliance of Mankato) would be permitted to contract directly with employers under a capitated arrangement and not be subject to state insurance regulation.

It is too early to learn anything from the Quality Health Alliance (QHA) demonstration. Todd Henry, QHA executive director, says that the group won't start working on direct contracting with employers in its nine-county service area until later in 1996. QHA first had to resolve network issues, namely whether the Mankato Clinic, the largest medical group in the area, would be a shareholder and participate in the alliance's ventures. (The clinic has chosen not to remain in QHA.)

Henry says local businesses are enthusiastic at the prospect of buying a health plan through the cooperative's joint venture with HealthPartners. It creates new competition and allows businesses to look to a local organization for services, not to the Twin Cities. Whether they will be interested in capitated arrangements remains to be seen. But first, both the providers and the employers need to get comfortable with the concepts.

Richard Korman, assistant general counsel for the Minnesota Hospital and Healthcare Partnership, expects that MHHP will ask the 1996 Legislature to permit two co-ops in southwestern Minnesota to enter the demonstration project. Given the short session, he doesn't expect to see bills to expand direct contracting broadly.

CREATING NEW COMPETITION

The notion that direct contracting will create new competition in the health care market is appealing to many employers and small medical practices, especially in Minnesota, where three large health plan companies control 76 percent of the enrollees in managed care plans. The possibility of new competition has been used to advocate laws that would permit broad use of direct contracting with a minimum amount of state regulation, under the assumption that more stringent regulations would only create barriers to entry by new competitors. A similar argument has been used to convince Congress that provider-sponsored networks should serve Medicare enrollees.

Randy Herman, a partner with the Minneapolis-based actuarial consulting firm of Reden & Anders, believes direct contracting does create opportunities for more competition. Herman has been working with BHCAG staff to structure payment methods that will shift some risk to providers but avoid business of insurance issues. "With the growth of managed care and consolidation in this market, there isn't a lot of choice from the purchasers' perspective," he says. "While there is some price competition among the big plans, history shows clear rate trends in a concentrated market: when one in-

creases rates, the others will follow."

When health plans have large provider networks, the purchaser doesn't see if one medical group is more efficient than the others in the network or has better outcomes. In effect, the health plan puts the costs and outcomes of all its provider groups into a blender and shows purchasers a purée that masks the differences between providers. Direct contracting with small care systems creates more price competition, because the purchaser will see which of the groups is more efficient.

In the past, Herman says, care systems have not been sufficiently integrated to make direct contracting viable. Contracting has been piecemeal, which is not efficient for an individual employer. By contracting through care systems, purchasers can eliminate some of the costs in the middle, though both providers and employers probably overestimate the amount of savings. Of course, Herman says, health plans could create some of the same competitive elements under the current system. They could create products in which prices are differentiated by care system and then pass on to purchasers the efficiencies of individual care systems. If BHCAG's purchasing strategy succeeds, we could see health plans offering those products.

RESOLVING REGULATORY ISSUES

The emergence of new provider networks has created a number of dilemmas for state legislators and regulators. Slowly, they are coming to grips with a complex task: balancing their desire to promote new forms of competition to achieve state health reform goals with the need to protect consumers from the consequences of new systems' failures.

Insurance regulators and others ask: If a self-funded employer pays providers under a capitated arrangement, isn't that shifting all risk to the providers and, therefore, creating insurance? And if it is insurance, shouldn't the employer be subject to state insurance regulations, such as mandated benefits? And shouldn't the providers be licensed by the state as an insurance company?

In authorizing new ways to orga-

nize integrated delivery systems or in dealing with networks that have emerged on their own, state legislatures have struggled to determine the proper regulatory barriers to entry by new organizations. In particular, they have debated what standard to apply to the net worth of new provider networks that are organized as HMOs, insurance carriers, or other regulated health plan companies. Standards that are too demanding will block the entry of new competitors into the market. But net worth standards that are too low may be inadequate to protect consumers if the new company becomes insolvent.

How these arrangements should be regulated depends, in part, on how much risk is involved and how it is shared between employer and provider. For example, some employers guarantee that services will remain available in the event of provider insolvency. States will need to determine the appropriate level of quality of care standards and develop a mechanism to investigate consumer complaints. States also will need to determine what level of protection against insolvency is necessary, through reinsurance or reserve fund requirements.

In the case of small employers contracting with a small number of provider groups, risk is higher that enrollees would be left without coverage if a provider becomes insolvent. The increased risk results from relatively low levels of experience and expertise in managing insurance risk and the availability of fewer assets to draw upon in case of insufficient revenues.

Hospitals point out that the risk to consumers is less than with a traditional insurance plan because provider organizations are able to deliver the services. Of course, that is more true when the organization includes not just primary care providers, but a full range of specialists and hospital services. Herman suggests that these entities don't need to be regulated as insurers so long as most services are provided through the care system and not contracted through other providers. Even when care is provided under contracts, the care systems can use insurance mechanisms to guarantee that services to

the consumer will not be interrupted.

The problem for the state will be to regulate adequately to protect enrollees' interests, yet not so tightly as to stifle new means of competition based on both quality and price. David Abrams, former director of

legal and policy affairs for the Minnesota Department of Health who helped design MinnesotaCare, suggests comparing the official position of state regulators with their actual enforcement policy: which cases do they go after? Now an attorney with

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Dorsey & Whitney, Abrams is representing the Buyers Health Care Action Group as it moves ahead with the direct contracting and provider payment components of its new model.

In deciding which cases to pursue, regulators will look at how much risk is involved, the potential for establishing precedent, which cases can be won, and overall issues of consumer protection: Who's buying coverage—several tiny businesses or a large, more sophisticated pool or single purchaser? "A stronger policy argument can be made that the state should step in to protect Joe's Hardware Store on Main Street, but not a company like Minnesota Power & Light," says Abrams. By that analysis, regulators may be less concerned about the BHCAG purchasing initiatives because the employers are very large and will contract with many providers, some of whom will also be very large. Even so, BHCAG has been careful to design its strategy to avoid regulatory concerns about its companies and providers entering into the insurance business.

The politics of the issue are in-

triguing. Abrams points out that although the BHCAG companies are widely seen as driving the market, they have been careful to stay away from the legislative fray. The hospitals have sought to portray the issue as a small-scale rural concern for community hospitals and physicians, affecting a small number of consumers. Although the large Twin Cities entities don't get mentioned in the debate, legislative decisions to bless certain kinds of direct contracting could ultimately affect them and large groups of enrollees.

Minnesota HMOs have expressed their concerns about unregulated provider networks accepting financial risk. They don't oppose new competitors entering the market, they say, so long as the newcomers are subject to the same requirements for capital, reserves, consumer appeals, and so on, as the HMOs now face. In other words, they are prepared to compete on the proverbial level playing field.

Abrams suggests the issue may not be one of maintaining a level playing field but, rather, determining

the field's tilt. Organizations are fighting over billions of dollars spent by employers. Under current regulation, the big plans get a piece of almost every health care dollar. They capitate large provider groups or rent their insurance license to provider organizations. Whether the playing field is level—or merely has a new tilt—depends on where you're sitting.

It will be interesting to see how state regulators make their call, especially with a new commissioner at the Department of Commerce. That department has been the most market oriented of the state agencies, yet it also follows closely the NAIC view of regulation. New Commissioner David Gruenes, a former state representative, was one of the original "Gang of Seven" that designed MinnesotaCare in 1992, but he later opposed many aspects of the state's reform initiatives.

CONCLUSION

Providers have decided that they want to move up in the health care food chain and to assume many of the functions now performed by HMOs and insurers. Employers, seeking to promote competition and employee choice, are interested in contracting directly with provider networks. In the process, they have confused state regulators, who are used to overseeing traditional insurance organizations. The challenge for state regulators and legislators is to devise methods of oversight that protect the public's interest while at the same time encouraging the emergence of new competing organizations in their markets.

MM

Allan Baumgarten is a consultant on health care policy and finance and author of "Minnesota Managed Care Review" and "Colorado Managed Care Review," annual reports analyzing key trends and issues in those markets. Kathleen Vanderwall is a management analyst in the Health Economics Program of the Minnesota Department of Health. This article is based partly on "Direct Contracting," Health Economics Program Issue Paper, Vol. 1, January 1996, which was prepared by Vanderwall at the Department of Health.



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FEBRUARY 1996

Feb. 10-14 **Selected Topics in Internal Medicine** Mayo Foundation; Rancho Bernardo Inn and Resort, San Diego, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 22-23 **Burn Care Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Feb. 28 **Fibromyalgia Conference** Arthritis Care Program at Abbott Northwestern Hospital, Courage Center, and HealthEast; Hilton Hotel, Bloomington, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Feb. 29-March 2 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MARCH 1996

Mar. 7 **Annual Gentle Journey Conference: Palliative Medicine's Approach to the Relief of Suffering** Twin Cities Hospices; Sheraton Inn-Midway, St. Paul, MN. CONTACT: Lee Cummins, 1450 Energy Park Drive, St. Paul, MN 55108; 612/232-2600.

Mar. 7-8 **Family Medicine Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 22 **Occupational Medicine Update** St. Paul-Ramsey Medical Center; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Sharon Kopp, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Mar. 22-23 **Advanced Life Support In Obstetrics (ALSO)** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Mar. 28-29 **Critical Care 1996** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

APRIL 1996

Apr. 1-3 **Management Strategies in Complex Congenital Heart Disease** Mayo Foundation; The Pointe Hilton at Squaw Peak, Phoenix, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 11-12 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Apr. 12 **ENT for Primary Care Physicians** St. Paul-Ramsey Medical Center and HealthEast; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 13 **Minnesota Urological Society Spring Seminar: An Update on Pelvic Floor Dysfunction, Urinary Incontinence, and Female Urology** Minnesota Urological Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Apr. 18-19 **Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 19-20 **Minnesota Orthopaedic Society 12th Annual Meeting** Minnesota Orthopaedic Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Apr. 25-26 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

Apr. 26 **Twelfth Annual Duluth Heart Conference** Duluth Clinic; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Fifth Avenue Building, Duluth, MN 55805; 218/725-3838.

Apr. 26-27 **Advances in Polycystic Ovary Disease** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

M A Y 1 9 9 6

May 17-18 **Allina Pregnancy Care Initiative** Allina Health System; Radisson South, Bloomington, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

May 17-18 **Using Computers to Help Manage Clinical Information** American College of Physicians and Allina Health System; Earle Brown Continuing Education Center, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

J U N E 1 9 9 6

June 12-15 **Sixtieth Annual Course on Advances in Trauma and Critical Care Surgery** Department of Surgery, University of Minnesota Medical School; University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 13-15 **Minimally Invasive Coronary Bypass Surgery Symposium** Minneapolis Heart Institute Foundation; Hyatt Regency, Minneapolis, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780,

PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

June 25-29 **Internal Medicine 1996: Advances and Controversies** Mayo Clinic and the Department of Medicine, Royal College of Surgeons, Ireland Medical School; Dublin, Ireland. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

A U G U S T 1 9 9 6

Aug. 8-10 **Third Annual Symposium on Biomedical, Biopharmaceutical, and Clinical Applications of Capillary Electrophoresis** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Aug. 24-27 **International Symposium on Radioiodine** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

S E P T E M B E R 1 9 9 6

Sept. 9-10 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

O C T O B E R 1 9 9 6

Oct. 3-5 **Mayo Vascular Symposium 1996: Advances and Controversies in the Multidisciplinary Management of Vascular Disease** Mayo Clinic and North American Chapter of the International Union of Angiology; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Oct. 4 **Insights and Outlooks '96** St. Paul Heart Clinic; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 11-12 **Advanced Life Support in Obstetrics** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 14-16 **1996 International Meeting on ANCA and ANCA-Related Diseases** Mayo Clinic and Mayo Foundation; Phillips Hall, Siebens Building, Mayo Clinic, Rochester, MN. CONTACT: Kay Kenitz, 200 First Street SW, Rochester, MN 55905; 507/284-8399.

N O V E M B E R 1 9 9 6

Nov. 4-5 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

Mar. 22 **HIV Update** Allina Health System, Children's Health Care, HealthEast, Park Nicollet Foundation/Health System Minnesota, Hennepin County Medical Center MATEC, Minneapolis RMEC, Department of Veterans Affairs, St. Paul-Ramsey Medical Center, and the University of Minnesota; The Metropolitan, Golden Valley, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

E N D U R I N G M A T E R I A L S

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Sue Burmeister, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3216.

Printed Material: **Physicians' Update: Bloodborne Pathogens** Medical Education Group Learning Systems. CONTACT: MEGLS, Internet address: <http://www.cme.edu>; or call 800/547-0308.

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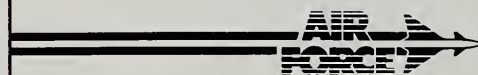
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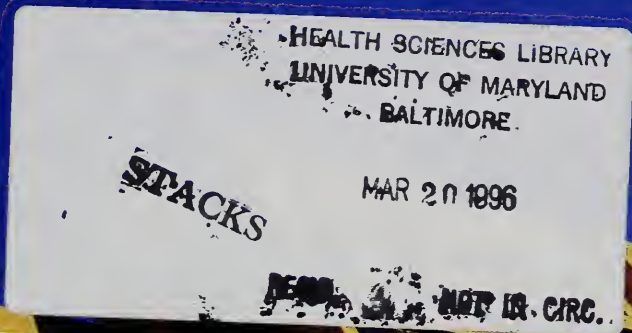
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Minnesota Medicine

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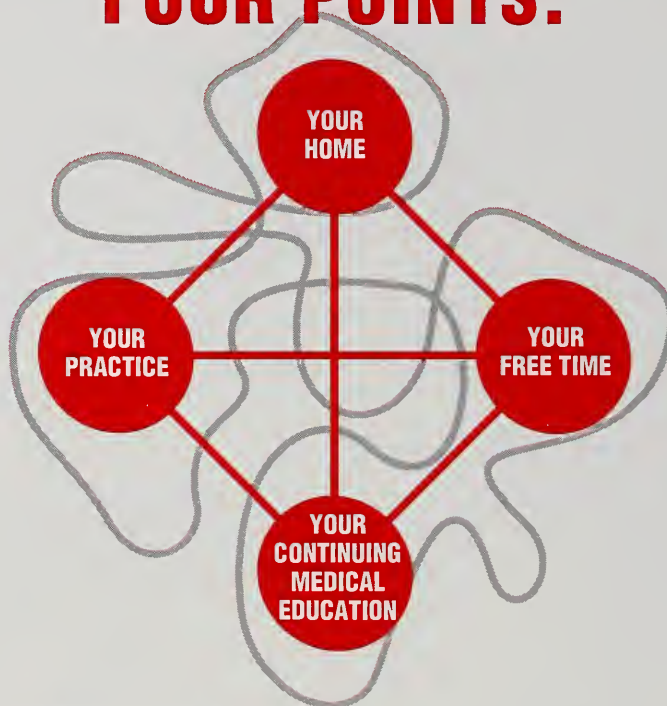


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Cover photo of the Phillips-Wangenstein Building, University of Minnesota, by Mike Burian.

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Numbers Part Deux or Making Sense of Statistics

Numbers? Not again! But I am undaunted by charges of statistical sadism. The previous *Media Watch* (December 1995, page 2) merely dabbled with the problem of how numbers can enhance or impede the medical education of the non-medical public. Further light comes from a small, enjoyable book by John Paulos, the author of "Innumeracy" and mathematics professor at Temple University in Philadelphia. In his most recent book, "A Mathematician Reads the Newspaper" (Basic Books, 1995) Paulos writes wittily on politics, health, and sports and shows how numbers in the daily press can warp our understanding of issues.

Numbers aren't just black and white. What they mean is colored by the psychology of the beholder. Paulos illustrates this with the three "A" concepts: availability, analogies, and anchoring. Availability means that people tend to make judgments based on what first comes to mind (is available). Analogies lead readers to quickly accept superficial similarities as a basis for deciding about more complex problems. Anchoring describes the phenomenon of people becoming tied to the first idea presented (such as estimating populations after being given a suggested number). What the three A's tell us is that any audience comes with a bias or can be quickly inculcated with a bias, which distorts the accurate transmission of information and how readers interpret statistics.

Communication is also distorted by human need for certainty. In medicine, we live with uncertainty. Much of the disease we encounter is "idiopathic," "essential," or "cryptogenic," all smoke words for "we

don't know." We frequently diagnose to a point and then swallow the unknown parts and treat. We accept unknown causes (or blame them on viruses) and wrestle with 80 percent probabilities.

But many people are uncomfortable living with uncertainty, particularly when the event in question is dramatic, says Paulos. They are abetted by a legal system that must find a source of negligence. Chance is not allowed. As Paulos says, "Uncertainty is a common and sometimes unavoidable state of affairs in science, but judges, lawyers, and juries often act as if every question has a definitive answer if only the witness thinks hard enough, the experts calculate long enough, and cover-ups are exposed." With such mental preconditioning, readers jump for numbers that prove causes or enshrine treatments.

Paulos faults the news media for their reliance on the "reputable source." All sources, regardless of repute, have their own slant. Yet reporters sometimes accept their pronouncements as gospel proof. According to Paulos, responsible journalism should seek and report "benchmark figures, operational definitions, and simple arithmetic" that provide background and potential critique of the oracular source.

Health articles form the meat of this book. As noted in the previous *Media Watch*, medicine is not easy to explain. Indeed, Paulos suggests that "health statistics may be bad for our mental health." He understands what all medical practitioners have repeatedly seen—people worry about their health, fear disease, and are susceptible to the anecdote of "Larry next door." They also tend to be swayed by absolute numbers instead of incidence percentages, attracted by multiples of 10, and alarmed by

sensational, though statistically small, problems (cocaine deaths vs. alcohol deaths, nuclear power health hazards vs. lead exposure). Paulos preaches perspective, putting the numbers in a comprehensible context.

That is Paulos' pervading pearl for practitioners of medicine and journalists reporting on it. Numbers can inform or baffle. To marshal them to tell an accurate story, media and medicine need to know where they came from, judge their reliability, and place them in an understandable context for our audience. And we need to know our audience—what words they know, what concepts they grasp, and what fears they bring.

MM

Media Watch is an occasional column written by Minnesota Medicine's editor-in-chief, Charles R. Meyer, M.D., an internist with Consultants-Internal Medicine in Minneapolis.

An ongoing dialogue about numbers in daily life can be found in the magazine *Chance*, which is accessible online on the World Wide Web at <http://www.geom.umn.edu/locate/chance>.

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The New 'U'

Marching to a Different Beat

Charles R. Meyer, M.D.



"Medical academia has traded white coats for business suits and donned running shoes to keep up with the hectic pace of managed care medicine."

Fairview Health System, but will retain control of its research and training programs. The Fairview gambit gives the university four P's: productivity, patients, primary care, and a pipeline to an outpatient clinical laboratory for students and residents.

The university's plight is common in medical academia. U.S. academic health centers (AHCs) could face a dry tap in the coming years. A stingy Congress has proposed 50 percent cuts in federal graduate medical education support, which in 1994 supplied AHCs with \$1.9 billion in direct, and \$4.2 billion in indirect, funds (see related article, page 26). Inpatient censuses, expected to shrink 24 percent over the next four years, threaten the crucial clinical practice well, which provided 50 percent of the funds for medical education in 1993-94. Managed care has

hesitated to connect its main to AHCs, which it thinks reek of expensitosis. Without change, it could be a parched millennium for AHCs.

And change they have. Nationally, AHCs have adopted a collage of the following six strategies:

1) acquire a primary care base, either unilaterally like the University of Pennsylvania or in partnership like Duke;

2) ally with a primary care base, as the University of Minnesota is doing;

3) sell the farm—Tulane recently sold its university hospital to the proprietary giant, Columbia/HCA;

4) centralize internal organization—whether the form is a practice plan or a physician-hospital organization, the intent is to perform a Frederick the Great-like unification of feudal fiefdoms;

5) adapt to managed care by shifting the emphasis in teaching to ambulatory settings, cost-effectiveness, and an epidemiological approach;

6) attract managed care by contracting with HMOs for integrated services at a global fee (Kaiser/Georgetown for cardiac surgery) or by cooperating with managed care to promote practice efficiency (Tufts) or high-tech research (Harvard/U.S. Surgical Corp.).

Academic medical centers of the '90s must be scholarly and skillful, but also lean and mean.

If you walk the paths of the University of Minnesota in five years, you likely will see ivy and white coats and perhaps even some tweed. But the medical education offered to university medical students and residents will be different from past days. Students will still auscultate hearts and palpate abdomens, but they also will learn the pulse of practice in the world of managed care. MM

Ah, academia. Undergraduates stroll by ivy-draped walls and engage in dialogue with tweedy, pipe-smoking professors. Medical students and residents tap the Oslerian wisdom of white-coated attendings carrying templates of Harrison's textbook in their cerebral cortexes. The pace is slow, and knowledge advances because the tweeds and the white coats have only truth and research to think about.

Whether this vision ever existed, it is clear that today medical academia has traded the white coats for business suits and donned running shoes to keep up with the hectic pace of managed care medicine in the '90s. Our University of Minnesota Medical School and Hospital is a microcosm of the metamorphoses occurring nationally at academic health centers. This month's *Minnesota Medicine* puts the "U" under the scope to see what the new animal will look like. To give historical perspective, we excerpt an editorial from my predecessor, Richard Reece, M.D., on the university's challenges a decade ago (page 10). The rhetoric sounds ironically familiar.

As described in this month's cover story (page 16) and Face to Face profile of Frank Cerra, M.D., dean of the Medical School (page 6), changes were afoot prior to November's announcement of a Fairview-university affiliation. The university had launched a health center-wide re-engineering project, which borrowed a page from Management 101, identifying three businesses—research, teaching, and clinical practice—and focusing the organization to run those businesses. The affiliation plans dovetail nicely with this scheme; the university has tentatively agreed to transfer ownership of the University of Minnesota Hospital and Clinic to

Educating Tomorrow's Doctors

By Kim Palmer

Frank Cerra remembers the moment he decided to become a doctor. As a 12-year-old boy growing up in Worcester, New York, a tiny community in the Catskill Mountains, he became deathly ill. "Septic shock," he says. "Damn near killed me."

Cerra regained his health and found his calling. "I loved biology and I liked people and solving problems," he says.

Today, as dean of the University of Minnesota Medical School, a post he assumed last May, Cerra still relishes challenges, which is a good thing, considering the scope of the tasks before him. Cerra's agenda includes retooling the Medical School's curriculum to prepare its graduates to compete in today's doctor-heavy managed care environment. He has committed himself to ensuring that the 'U' is among the nation's top 10 medical schools within the next five years. And he has a key role in the recently announced reengineering of the Academic Health Center in response to falling revenues. Last, but hardly least, he is an influential figure in the University Health System's pending alignment with the Fairview Health System, which will have a significant impact on medical students' training.

"We need to train the medical leaders of the future and put ourselves into a position to lead into the next century," says Cerra, a surgeon who graduated from Northwestern University School of Medicine in 1969 and came to the U of M in 1981. "And we have to do all that at the same time financing is dropping."

Asked which of these challenges has cost him the most sleep, Cerra shakes his head with a smile and says, "I don't sleep much. There's always something that catches my interest."

Boosting Morale

Cerra's warm, approachable manner and ready, bemused smile should serve him well in one of his earliest-stated priorities: boosting faculty morale. In an August 1995 interview with the Twin Cities *Star Tribune*, Cerra identified that as one of his first challenges. By early January, when he sat for this interview, Cerra described morale as much improved. "The faculty is seeing leadership." The reengineering effort and the Fairview merger have been received positively, Cerra says, "and we are going to achieve our goal of getting into the top 10." (The university currently ranks somewhere between 20th and 30th among all U.S. medical schools, he estimates, depending on the criteria used, or about eighth among public institutions.)

To continue the upswing in morale, Cerra is committed to getting information out to faculty and ensuring appropriate input from them.

Dean Frank
Cerra, M.D.,
leads the
University of
Minnesota's
Medical School
into the 21st
century.

"Communication can't be a one-way street. We need to develop a common mission and goals," he says.

Cerra's front-burner priorities include developing the new relationship with Fairview and rebuilding the infrastructure. The Medical School's accounting and accountability came under fire during the controversy over the ALG anti-rejection drug study, and Cerra is committed to upgrading both. "[The Medical School] is a \$350 million business, and it needs to be managed like one," he says. "The structure has to support the function. We had the wrong structure."

That doesn't mean the Medical School has to be managed like an auto manufacturing plant, he continues. "This is very people intensive. Education and research need an environment that's open, free, and promotes individual thinking. That's very different from a tightly run, tightly managed environment necessary for clinical care."

Retooling the Curriculum

The Medical School's curriculum is another high priority, Cerra says. "We have an excellent medical

product; I'd never be critical of that. But we need more business education, more modern health care education, including epidemiology, population-based care, team-based medical care, and outcomes assessment."

The practice of medicine today requires different skills and orientation because of managed care, Cerra says. Physicians can't just be experts at medicine; they have to strive for and achieve customer satisfaction, cost-effectiveness, and good outcomes, as well. "Medical care is now managed by managers," he says. "And even if managed care goes away, we'd still be looking at our curriculum."

In addition, the cost of medical training needs to be scrutinized, says Cerra. Today's typical medical school graduate has spent seven to 12 years being trained and is \$70,000 to \$80,000 in debt by the time he or she is ready to practice. "We need to see if we can reduce the time and cost of training, while maintaining the quality. There might not be any way to do that. But we need to ask some questions: What is it [doctors] really need to know? What are the most effective ways to teach them?"

Curriculum already is different than it was only a year or two ago, and it will be "absolutely different" a few years in the future. "We'll take some giant steps," Cerra says.

The Medical School has a task force examining a team model of medical care, including "everything from diagnostics to how you get people to take their pills," Cerra says. "The task force is looking at what team care means, trying to define its impact."

One anticipated impact is that team health care will reduce the need for doctors; the United States is already oversupplied with physicians, according to studies. Cerra cites, in particular, a report of the Pew Health Professionals Commission released last November, which called for "a wholesale closing" of U.S. medical schools over the next decade to head off a glut of doctors.

Minnesota, which has led many health care trends, is "right out there in front" in terms of physician oversupply, Cerra says. "It was a matter of national policy a number of years ago

PHOTOGRAPH BY BRUCE BAIRD



Frank Cerra, M.D., dean, University of Minnesota Medical School.

to train more physicians. And Minnesota responded very nicely. We bumped class sizes."

Concurrently, Minnesota was giving birth to the managed care movement, which has helped reduce demand for specialists. "Managed care is very well established here," Cerra says. "We're already saturated in specialties, and we'll be saturated in primary care in another four to six years."

The Pew Commission recommended that medical schools admit 20 percent to 25 percent fewer students by 2005, and the university does plan to reduce admissions, Cerra says. The Medical School currently accepts 180 students each year, plus 40 transfers from the two-year program at the University of Minnesota-Duluth. In the next four to six years, that number will drop to 140 or 150, Cerra says, noting that the reduction will come primarily from the Twin Cities campus. "Duluth is mostly primary-care focused, and we'd like to see Duluth develop as a national model for rural health care training."

Aligning With Fairview

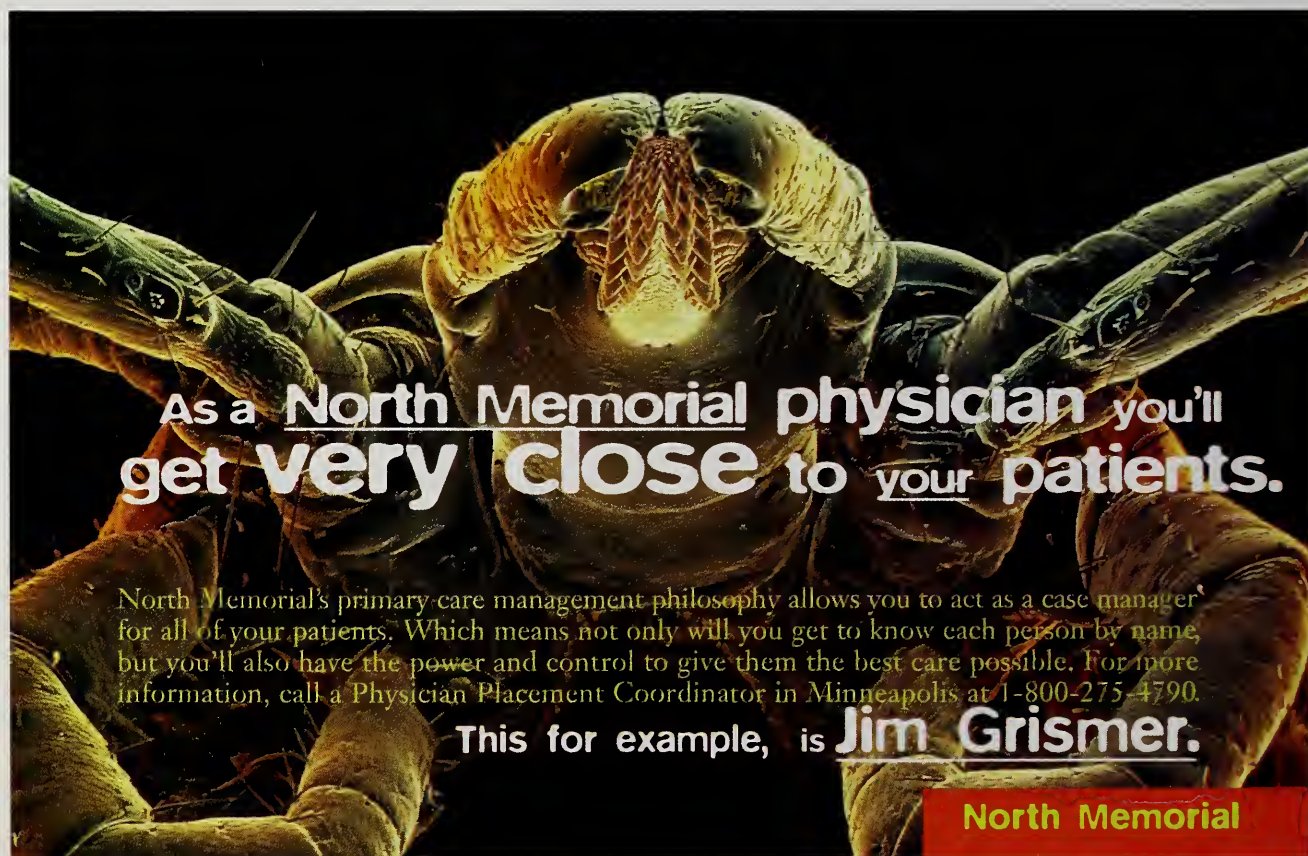
The Fairview merger is expected to have a significant impact on training university medical students, Cerra says. "It will help us do it a lot better and cheaper. Having access to an integrated health care system opens up tremendous opportunities for training physicians in a very different way. Basically, we've been inpatient fo-

cused. We don't provide full-service, birth-to-death care. Instead, we have an academic flagship focus. We need to teach our students efficiency, and private practice is better at doing that. Our students will be on site using managed care tools. It's a major shift in the whole educational paradigm."

The Fairview merger also will help ease the Medical School's revenue crunch. "This facility [University Hospital] currently has only 5 percent of the market," Cerra says. "We have to partner with somebody to get a source of patients." Currently, 40 percent of the Medical School budget comes from income earned by physicians. Physician income is falling, which threatens the long-term future of the University Hospital and Medical School. State money represents only 18 percent of the budget, Cerra says. "We're going to have to become more efficient and effective and also find other sources of revenue. There are a lot of possibilities, and it will take some dialogue to work things out." In the meantime, the Fairview relationship will help stabilize finances, he says.

Turbulence at the university hasn't had a noticeable impact on the Medical School's ability to recruit top people, Cerra says. "The number of applicants is increasing, and the quality of applicants is higher than it's ever been. The school here is outstanding and recognized as that. The commitment and vision are here." MM

Kim Palmer is a Minneapolis free-lance writer.



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The Awakening

This 1985 editorial recounts the tale of a sleeping giant—the University of Minnesota’s Academic Health Center—roused from complacency by the harsh realities of Minnesota’s health care marketplace.

By Richard Reece, M.D., 1985



ILLUSTRATION BY MIKE REED

Editor's Note: My glib predecessor, Richard Reece, had a penchant for puns and predictions. As an economist or horse handicapper will attest, committing predictions to paper is an invitation for future derision. The following excerpt of Reece's October 1985 editorial is intended not as an example of failed foresight, but as historical perspective on the University of Minnesota's Academic Health Center, which is featured in this month's *Minnesota Medicine*.

I was struck more with déjà vu than all is new when I read Reece's decade-old comments. The year 1985 saw the university reorganizing, needing the cooperation of community physicians to survive and thrive, trying to link with managed care to maintain patient flow, and agonizing over how to prepare students for working in a managed care environment. If that doesn't sound familiar, you haven't been reading Minnesota newspapers in 1995. Our profile (page 6) and cover story (page 16) detail today's "vu."

Reece concludes his article with the prediction that, like Rip Van Winkle, the university was "awakening from a deep slumber" and would "become a formidable competitor in two to five years." Dick's vision wasn't flawed; Rip just slept in. —CRM

The Sleeping Giant

Teaching hospitals have the potential of becoming formidable competitors. The University of Minnesota Hospital, in my opinion, looms as a sleeping giant arousing itself. Why? For three simple reasons: 1) its recognition factor among the general public; 2) the high proportion of its graduates among practicing Minnesota physicians; and 3) its concentration of specialists in one setting. The university and its faculty are marketable simply *because* they represent the university. With its 350 members, the university clinical faculty has the potential of becoming the largest multispecialty clinic in the Twin Cities.

What Is Happening

Like academic health centers (AHCs) throughout the country, the University of Minnesota medical center is struggling to adapt to the competitive health care marketplace. This struggle entails reshaping long-held attitudes by the Medical School faculty, creating a new image of the hospital and medical center, and reshaping the current organizations into corporate entities that can serve as vehicles to go to market in an increasingly competitive environment.

Opening a New Hospital

In March 1986, the university will open its new \$125 million, 432-bed facility. The question is: Can the university reshape its attitudes, mold a new image, forge new relationships with the outside world, and reorganize its structure in time to attract enough patients to service the debt of its spanking-new hospital and bring in enough capital to compete? To turn around a large hospital in today's competitive world requires at least two to four years. Given the complexity of a large academic health center and the speed of change in the health care marketplace, does the university have time to adjust?

Positioning to Compete

Only time will tell. But one thing is sure: the university's Academic Health Center is taking steps and making moves designed to compete:

1) The chiefs of the 18 clinical departments at the university have formed the University of Minnesota Clinical Associates. UMCA will try to unify the clinical chiefs, establish common billing practices, negotiate contracts with HMOs, initiate joint ventures with physicians and hospitals inside and outside the walls of the university, and, of course, market the clinical and technical skills of the university faculty members.

2) University Hospitals and UMCA have joined with Whitehead Associates of Greenwich, Connecticut, to strengthen Primary Care Network, a for-profit HMO designed to link the expertise of university physicians with referring physicians, most of whom are located in outstate Minnesota.

3) University Hospitals and UMCA are working together on marketing and corporate strategies designed to improve the image of the Academic Health Center, to evaluate its level of clinical services, to improve its relationship with referring physicians, to speed up referral letters, and to target its marketing toward patients in the Twin Cities and toward referring physicians outside the Twin Cities.

Corporate Reshaping

Health care market forces have begun to radically transform all U.S. academic health centers and teaching hospitals. These forces have been late in coming to academic health centers because these centers are coming off 25 years of unparalleled expansion. The American public has shown such open-ended gener-

osity toward expanding the medical-academic complex that academic leaders became complacent and thought of themselves and their institutions as immune to market forces—a cocoon for the lofty missions of teaching, research, and technology development.

Perverse Academic Incentives

I believe this federal largess has fostered perverse incentives that make competing difficult. The incentives have been to turn out specialists rather than generalists; to train doctors to function in hospitals rather than in outpatient settings; to reward those who do research rather than those who apply that research; to encourage participation in national rather than regional or local forums; to value those who write papers more than those who are skilled clinicians; to promote those who solve problems within the internal bureaucracy rather than those who seek outside opportunities; and to rely for management decisions on those who have mastered the body of medical knowledge rather than those who are versed in the managerial disciplines.

The Mindset

Here Eli Ginsberg describes the mindset that has evolved in academic health centers as a consequence of affluence: "A number of major transformations accompanied the cascade of funds into the leading academic health centers. The AHC was almost totally removed from university control once it became a contributor to rather than a beneficiary of central budgeting. The system of external financing for research reduced the authority of the dean to a point where he was beholden to his principal investigators rather than they to him. The heads of the major departments of the medical school, who in most instances were also the directors of the corresponding services in the principal teaching affiliate, became all-powerful barons by virtue of their control over research funding, residency slots, fellowships, training funds, and hospital beds. Each had his own kingdom."¹

Ginsberg goes on to say that he believes academic health centers will really be put to the test from 1985 to 1995 and that they "are much more vulnerable than assumed." Then he notes: "Different AHCs, depending on their circumstance and profit margins, have begun to reposition themselves. Some universities are reorganizing their principal teaching hospital as a separate corporation so that they will be buffered from the uncertainties of the hospital environment. Some teaching hospitals are working out new arrangements with their attending staff. Still others are entering into alliances with potential competitors or developing relationships with HMOs and PPOs, which will provide a more certain stream of patients, many of whom will require tertiary care."¹

Ginsberg's comments capture what is going on at the University Hospitals and what is occurring within its attending staff. Both the hospital and the staff are "repositioning" themselves to ensure a "more certain stream of patients." The Academic Health Center is going through a period of corporate restructuring as it tries to adjust to the present and prepare for the future.

Medicine versus Business

However progressive the university's preparations may be, there remains an unanswerable question: Can university and Academic Health Center leaders reshape their philosophical beliefs enough to be effective competitors in a tough marketplace?

By "philosophical beliefs," I refer mostly to a pervasive sense of wariness, uneasiness, and mistrust among academicians toward business. Many in the academic community, it is safe to say, simply do not trust corporations to allocate funds to the poor, the underinsured, the old, or to

"Can university and Academic Health
Center leaders reshape their philosophical
beliefs enough to be effective competitors
in a tough marketplace?"

—Richard Reece, M.D., October 1985

research and teaching enterprises.

The academic community, to use a Reagan administration phrase, does not feel it is competing on "a level playing field." Medical School faculty members question how much support they can give to each leg of the metaphoric three-legged stool—education, research, and patient care—that describes their mission. They ask: How much energy and resources and time can the university pour into clinical services to make them competitive without stinting on research and education?

Rashi Fein, an economist at Harvard Medical School, describes the academic dilemma this way: "The marketplace is an arena in which some win and others lose. The rules of the game are such that our teaching institutions and those that they serve will be the losers. There is simply no way that institutions with a commitment to teaching, research, and care for those (or at least some of those) who have inadequate or no health insurance can compete on price."²

Questions of Education

Provocative and profound questions keep cropping up about educating medical students and residents. How do you prepare students to work in an HMO? Do you change the curriculum to accommodate matters of money, management, cost containment, efficiency, and quality? Do you have those in training spend time off-site in HMO or multispecialty clinic settings? If national firms take over 50 percent of medical care by the 1990s, as health care visionary Paul Ellwood predicts, will this takeover fatally weaken the grip of specialty boards over postgraduate training? Should we turn freshly minted M.D.s over to the HMOs for training? How do you compete efficiently when the very presence of students

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and residents slows diagnostic workups and lengthens hospital stays? How can you train someone in the art of history taking and physical diagnosis when the patient is admitted at 10 a.m., operated on at 11 a.m., and discharged at noon? How can you run a thoughtful, reflective, and thorough teaching program under these circumstances?

In short, how do you turn your educational program inside out (from inside the hospital to outside in ambulatory care settings) and upside down (from an academic hierarchy to a corporate bureaucracy) at the same time?

I certainly do not know, but medical students are concerned about their future economic and practice environment. Last year, six months into their education, freshmen students at the university sponsored the seminar "The Marriage of Management and Medicine: For Better or Worse?"

Thoughts on Quality

In a competitive, price-conscious market, the plaintive cry you hear most often among physicians, particularly academic physicians, is "When are we going to talk about quality?" Quality in health care lies in the mind and experience of the beholder. To the academic health

care specialist, quality care may exist by the simple virtue that care is being rendered in a university setting. After all, do not university faculties attract "the best and the brightest?" Do they not offer the latest in research? Do they not provide the latest in treatment, and are they not on the leading edge of technology? In many instances,

particularly in high-technology fields, the answer to these questions is yes.

Because the bulk of University Hospitals' revenues do not come from high-technology procedures nor from treating rare diseases, most money still must come from mundane operations and common illnesses. For certain fields—transplants and treatment of childhood

leukemias—the university will remain the epitome of "quality," but other hospitals feel they can offer the same or superior quality for procedures done more often or diseases seen more often in their own institution than at the university. So the question for the present is: Can the university translate its quality into a marketing asset that will attract the right mix of patients? For the future, the question may be: Can the university document that it has a superior outcome for a given category of disease?

Summing Up

The University of Minnesota Hospitals and academic faculty stand in the first rank among American academic health centers; yet each is threatened and vulnerable to current and future competitive economic forces. Each is in the process of restructuring itself internally to cope with the external environment. One of the imponderables is whether sufficient numbers of management and faculty will be able to modify traditional attitudes in enough time to cope with the new economic realities. It is my own view that the University of Minnesota Academic Health Center is awakening from a deep slumber and has the intellectual, management, and economic resources to become a formidable competitor in two to five years.

MM

Richard Reece was editor-in-chief of Minnesota Medicine from 1975 to 1990.

Excerpted from Reece R. The corporate transformation of medicine in Minnesota: myth-breaking, image-making, and corporate reshaping at the University of Minnesota Hospitals and Medical School. Minn Med 1985;68(10):731-41.

REFERENCES

1. Ginsberg E. Academic health centers: a troubled future. *Health Aff* 1985;4:6-21.
2. Fein R. Choosing the arbiter: the market or the government. *N Engl J Med* 1985;313:113-5.

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A LOFTY MISSION

By Darlene Gorrill • Photos by Mike Burian

The news that made headlines last November marked yet another realignment of the local health care scene. In declining health and in need of a lifeline, the once hale and hearty University Hospital and Clinic announced plans to merge with Fairview Health System to instill the

hospital with new vigor and improve its chances for survival in an intensely competitive health care market.

Although a very public partnership, the merger is only one part of the prescription for a radical overhaul of the university's teaching, research, and clinical care activities. In 1995, the university's Academic Health Center (AHC) spent much effort diagnosing its own symptoms and developing a treatment plan.

The prognosis is improving, says William Brody, M.D., Ph.D., the Ac-

An ivory tower approach won't keep the U of M Academic Health Center on top, says the team in charge of its revitalization.

PHILLIPS-WANGENSTEEN BUILDING, UNIVERSITY OF MINNESOTA.



ademic Health Center's first provost, recruited in 1994 to restore the center's long-term health. To thrive, the university must comply with a complex treatment regimen that calls for totally revamping the AHC's operations. From the start, Brody made it clear that every policy, every aspect of the Academic Health Center is on the table. Status quo is not an option, says this Stanford-trained M.D. and electrical engineering Ph.D. who once ran a successful business venture.

WHAT AILS THE AHC?

The University of Minnesota is not struggling alone. The viability of academic health centers is threatened throughout the country. Profound shifts in the way health care is purchased, financed, and delivered are forcing these revered institutions to reorganize, cut costs, and form alliances with outside practices and health systems. The nation's 120-some academic hospitals are finding that ivory towers have no place in a competitive market that emphasizes flexibility, low prices, primary care, and the efficiencies of centralized decision-making.

But the University of Minnesota's situation is especially critical because of the Twin Cities' advanced managed care market. "We may not have kept our heads in the sand longer than anyone else, but our market changed faster," says Brody, who before coming to Minnesota chaired a restructuring committee at Johns Hopkins. "Now we have to move faster to create a structure that will make us viable in that market. We have to literally create a model for the rest of the nation. That's the challenge," Brody told the University of Minnesota's *Update*.

Tough times and tight money are indeed forcing dramatic change at the University of Minnesota Academic Health Center. Like most of its sister institutions, the University of Minnesota Hospital and Clinic finds itself in a market dominated by managed care. Insurers are increasingly unwilling to cover the extra cost of research and education, and at the same time, the hospital's patient base is declining—losses the university hopes to make up for with its pending Fairview merger.

The supply-and-demand problem goes beyond hospital beds. Like all academic in-

stitutions, the university's medical center has focused on training specialists and providing tertiary care; now the market is saturated with specialists, and the current demand is for primary care and interdisciplinary teams that include allied providers. The university is responding by cutting back its residency program, reducing its medical school class size, and expanding its teaching of interdisciplinary health care. In addition, it must look critically at its own complex and sometimes unwieldy structure.

The system that once worked can no longer move fast enough to meet changing needs, says Brody. The AHC must do a better job of satisfying its customers and running its operations with business-like controls, he says. Last year, Brody started the reformation by creating an interdisciplinary team of AHC faculty and staff known as the Quality and Reengineering Technology Committee (QRTC). In typical Brody style, he gave the committee its charge, set the parameters, then stepped back, allowing the team to forge ahead.

Brody asked the QRTC to reexamine the AHC's purpose, to craft a mission statement, and to articulate a case for change that would involve all AHC disciplines. The AHC currently includes the Twin Cities and Duluth medical schools, dentistry, nursing, pharmacy, public health, veterinary medicine, related centers and institutes, and the University Health System, which operates the University Hospital and Clinic.

Meanwhile, Brody and hospital leaders set out to determine the fate of the University of Minnesota Hospital, a task that led to the hospital's planned merger with Fairview. With these activities, all roads lead to change for the AHC.

A DAUNTING CHARGE: REENGINEERING THE AHC

In July, the QRTC began tackling its daunting charge—"reengineering" the AHC's future. Its efforts should radically change the Academic Health Center. "There won't be a person in the organization who isn't touched by this in a positive way," says Leo Furcht, M.D., who directed the QRTC and now serves as vice provost in charge of reengineer-

"The biggest threat to the AHC's future is inaction—for the AHC to rationalize that its educational and research programs are pretty good, that its problems are temporary, and that it really doesn't have to change very much. If that happens, some morning we'll wake up and discover we have a second-rate institution and ask, 'Why didn't we act sooner to change things?'"

—State official,
QRTC survey

ing the Academic Health Center.

The reengineering process brings with it a new focus for academia—a close look at the marketplace and at the university's many customers. "Reengineering means dramatic change in response to an external world that requires a different approach," says Ron Franks, M.D., dean of the University of Minnesota-Duluth School of Medicine and a QRTC member. Increasingly, the language and ideas of business are becoming an accepted part of academic life.

"For me, [reengineering] means starting and developing a system of care, education, and research that is focused, efficient, and customer-oriented," says William Jacott, M.D., AHC assistant vice president and interim head of the Department of Family Practice and Community Health. With such a process, nothing is sacred, Jacott emphasizes.

The committee approached its work with

an open mind and a blank slate, which allowed it to consider any possibility, says Furcht, also head of the Department of Laboratory Medicine and Pathology and director of the Biomedical Engineering Center. "We had a refreshing perspective that said, 'If you had to do it over, would you do it the same way? And if the answer is no, how would it be different?'"

As a process, reengineering requires the collection and use of data to drive decisions. In the first phase of its work, the committee surveyed students, health care industry representatives, and other academic institutions. The committee learned that the university isn't alone in facing major change and that Minnesota industry supports and values the AHC. It found that the state's decreasing financial support means students are paying more for their education. It learned that disciplines must work much more closely together on education and research activities.

And it discovered that students and employers want more opportunities to help shape the education product.

As a result of its work, including the surveys and a series of town meetings, the committee developed its case for change, with the following educational goals: significantly improve student satisfaction; modify curriculum to better meet student and community needs; lower the cost of education per graduating student; and build continuing education opportunities for current professionals.

The committee also concluded that the AHC's three different "businesses"—teaching, research, and clinical practice—need three different organizational approaches, says Furcht. Research thrives better in a fast-paced, more loosely managed environment, with an emphasis on product leadership, he says. Teaching requires a focus on providing value with a strong educational product, and clinical practice involves an intensely close customer relationship.

A proposed structure for these

"There won't be a person in the organization who isn't touched by this in a positive way."

—Leo Furcht, M.D.



businesses calls for a vice provost of education, a vice provost of research, and an executive director of clinical affairs, each reporting to the provost but individually responsible for "business" operations. Frank Cerra, M.D., dean of the Medical School, has been appointed interim vice provost of education, but the other positions have yet to be filled.

Furcht is leading the next phase of reengineering—when the rubber hits the road and the committee's ideas turn into specific actions. Ten new design teams, with about 70 members from throughout the AHC, will work for about six months in the following areas: organizational detail; human resources, compensation, and incentives; tenure and governance; management information requirements; funding and budgets; curriculum; research strategy and priorities; patient flow and clinical focus; communication and change management; and information technology.

AN IMPROVED PRODUCT

Consider the complexities of modifying a medical school's "product"—a medical education—to meet the demands of a managed care-focused market. It takes more than seven years to complete the process at a cost of more than \$100,000.

As the Medical School's dean, Cerra is leading the school's efforts to adapt to market pressures, and he's well aware of the challenges (see the Face to Face profile of Cerra, page 6). In response to an overabundance of physicians in the marketplace—particularly specialists and subspecialists—the Medical School has reduced the number of university-sponsored residency training slots by 25 percent over the next three years.

The school will monitor its admissions in the next three to four years and likely will reduce the number of new students by about 30 percent. Currently, the Medical School enrolls about 800 students and more than 1,300 residents. Controlling enrollment helps ensure that graduates find positions at the end of their studies, but the need for change extends beyond numbers.

"We have to find a different way to train physicians," says Cerra. Although QRTC surveys revealed that employers appreciate graduates' clinical skills, today's employers

want much more. Physicians who complete their education today are much more likely to be hired as part of group practices or health care organizations, instead of entering private practice. They collaborate with other physician specialists and a growing number of health care professionals. But their education doesn't emphasize such interaction among disciplines, nor does it reflect the demands of a managed care environment, says Cerra.

It's not a matter of abandoning the clinical science, but adding to a student's education, says UMD's Franks. "Now, students will not only have to look at the molecular level, human functions, and disease, but also at the community and society at large to improve health."

To support major curriculum reform, Brody has asked the 1996 Legislature for \$5 million and another \$15 million to improve technology used for education. In addition, the UMD School of Medicine plans to develop an interdisciplinary rural health initiative to prepare physicians, nurses, pharmacists, and other health care professionals for rural practice. The effort fits with the university's commitment to the state, as well as with its desire to break down boundaries among disciplines, says Franks.

NO MORE BRICKS AND MORTAR: THE HOSPITAL'S FATE

While the QRTC hammers away at its reengineering process, Brody is busy with another AHC transformation that will have a major impact on medical education and research: a massive restructuring of the University of Minnesota Hospital and Clinic.

Good medical training requires a strong relationship with a clinical facility, says Cerra, and the Academic Health Center has relied on the University of Minnesota Hospital and Clinic (UMHC) for patients and as a place to advance education and research. The relationship is crucial for AHC to maintain excellence in both areas, he says.

While the UMHc fills the role of academic teaching hospital, the organization also operates in Minnesota's highly competitive managed care environment. In recent years, its teaching responsibilities have taken

"The AHC should develop an 'institute of managed care' that would serve as a neutral ground for all competing organizations to study the most effective practices for providing health care."

—HMO executive,
QRTC survey

a financial toll on its business operations. A year ago, the Associated Press reported that UMHC physicians saw their pay drop by an average of 30 percent during the previous year because of managed care pressures.

In the last three years, the organization has reduced expenses by almost \$50 million and worked to improve its relationship with payers and physicians, says Peter Rapp, general director of the University Hospital and Clinic. But at the same time, it also has lost a steady stream of patients, threatening the AHC's educational and research missions.

The university considered several options for the hospital's fate, including closing it, operating it on a smaller scale, or looking at possible partnerships within the health care community. Operating the hospital on a smaller scale would not solve current financial and marketplace concerns, and closing it would hurt the university's ability to fulfill its mission, says Brody. For any given research

project, the university probably could identify off-campus clinical settings where students and faculty could collaborate, but finding appropriate settings for every project and idea would be inefficient and most likely would inhibit research breakthroughs, he says. Informal discussions among faculty and staff in the hospital lounges and hallways often make the difference in research projects.

"There's so much interaction that occurs with one setting and builds interdisciplinary bridges," says Jacott. "If you have a variety of research settings, it will be very difficult to promote the interaction of ideas, and that is how discovery is born."

Ultimately, Brody and the hospital board determined that the university needs a hospital in close proximity to the AHC to maintain the delicate balance between teaching students, conducting research, and applying research in a clinical setting, but decided the

university should concentrate its efforts on teaching and research—not on bricks and mortar. That left the university looking for a partner that could more competitively run the University Hospital.

THE FAIRVIEW OPTION

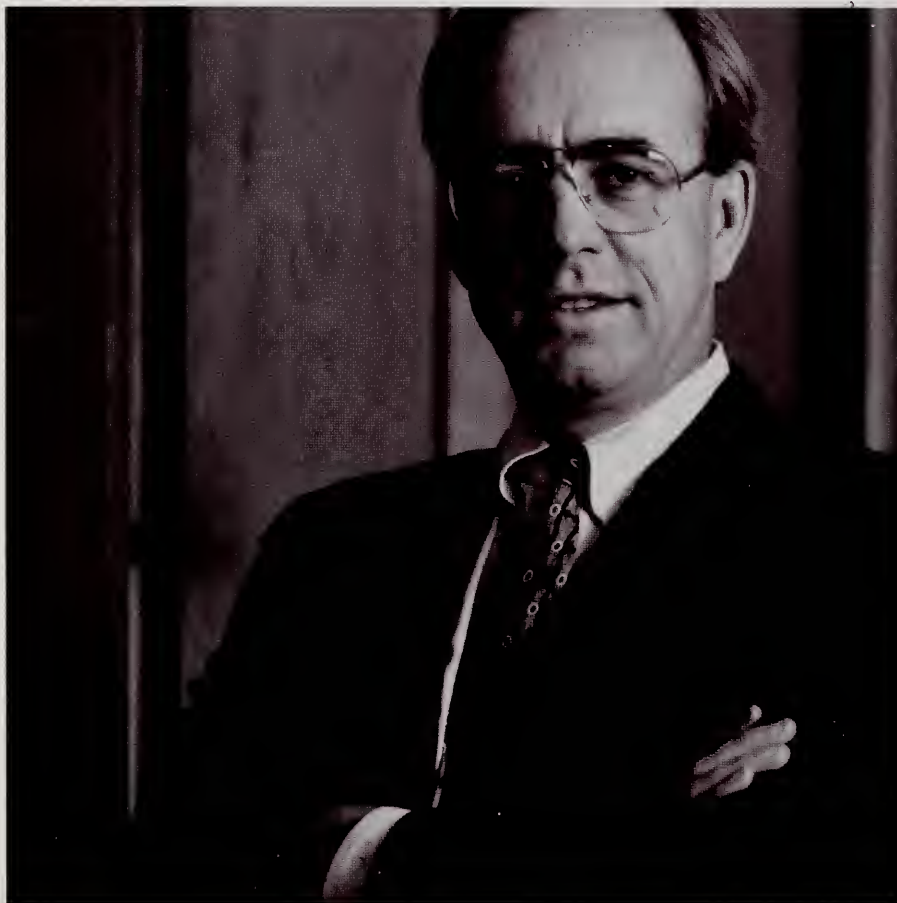
Following rumors of a possible joint venture with a competing large health system, the university signed a letter of intent with Fairview Health System to pursue a merger. In January, the university's Board of Regents and Fairview's Board of Directors approved a tentative plan to transfer ownership of the University Hospital and Clinic to Fairview Health System.

"This agreement is a significant step forward in the Academic Health Center's efforts to meet its crucial, dramatic, and urgent need for a stable patient base to support our research and teaching missions," says Brody.

With the January approval, the organizations received the green light to enter "Phase III" of the proposed merger, or the "due diligence" phase. During due diligence,

"The university and Fairview complement each other in many ways."

—Peter Rapp



both organizations gather the financial and legal information they need to complete the merger agreement. Phase III, expected to take about four to six months to complete, also involves examining in greater detail the ways in which the integration of services and facilities will work.

Under the current plan, the university would invest \$20 million and set aside another \$20 million to support the merged system during its first few years; in exchange, Fairview would assume most of the University Hospital's \$140 million in debt. The University Hospital and Clinic would operate as a separate division of Fairview, with its own division board of trustees. Half the board's members would come from the university and half from Fairview, but the university would have an ex officio voting member (the Medical School dean), giving it a majority. To protect university interests, one provision of the agreement requires a 75 percent vote of the board to sell assets or make changes in control of the division. The plan calls for only the merger of hospital operations. The university retains control of its research and training programs.

Both organizations say they hope to achieve a balance between the two work forces, but they need to resolve some important human resource issues. Will university employees become Fairview employees and lose university benefits? Will the unions currently in place at the university remain? University employees have voiced concerns about job security, pensions, insurance, and other issues all currently under debate. As *Minnesota Medicine* goes to press, the issue has reached the state Legislature in the form of bills aimed at protecting hospital employees.

The merger details may be sketchy, but the attraction that drew these partners together is more obvious. "We complement each other in many ways," says Rapp. With its medical specialists, the university offers Fairview a stronger hold in the tertiary care market. The University Hospital will likely serve as Fairview's main center for tertiary care, working closely with university faculty and Academic Health Center departments. Affiliating with Fairview will give the university new possibilities as a partner in a community health system, as well as a larger

patient base for teaching and research activities. Fairview's strong presence in the metropolitan area will mesh well with the university's connections to greater Minnesota, say supporters of the merger.

The university and Fairview already have collaborated in several successful joint efforts. The two share a family practice clinic, and Fairview serves as a site for family practice training. And in July 1994, the two combined their obstetrics, gynecology, and newborn intensive care services on the Fairview Riverside campus. This smaller-scale marriage helps pave the way for the larger and more comprehensive merger, says Rapp. "We know each other, and we have experience looking at the different ways we work."

A CONSOLIDATED PRACTICE

Academic hospitals are well known for their complex organizational structures that include many centers of power. The staffs are usually organized by specialty departments or divisions, with each department billing separately and controlling most of its own finances. As a step toward creating a consolidated practice, the University of Minnesota Hospital and Clinic was legally joined in 1993 with university physicians—privately incorporated as the University of Minnesota Clinical Associates (UMCA)—to form the University of Minnesota Health System (UMHS). In addition, UMCA, a medical services organization for the university's 18 physician practices, is considering ways to bring the separate practices together in a single group practice. Roby Thompson, M.D., chief medical officer of UMHS and chair of UMCA, expects that details for the consolidated practice organization will be finalized early this year.

The physician consolidation offers several advantages. It gives the university a larger group to respond to marketplace requests for proposals. And creating one organization will help improve access to the university. "It will allow us to allocate resources more efficiently, and it will allow us to speak with a stronger voice," says Thompson, also a professor of orthopedic surgery.

The UMCA consolidation will allow the university to bring one physician group instead of separate practices to the Fairview

"What three things would you not change? Academic freedom, academic freedom, academic freedom. What three things would you change? Tenure, tenure, tenure."

—AHC faculty member,
QRTC survey

merger. But blending two diverse groups of physicians—the UMCA group with its academic focus and Fairview Physician Associates with its community-based focus—will challenge the merger architects, says Brody. Involving physicians in the integration process is key to bridging their different cultures, he says.

A group practice also means that the university can take greater advantage of an investment in outcomes measurement. With the Clinical Outcomes Research Center—a collaboration between the School of Public Health, the Medical School, and the hospital—the university has an opportunity to integrate its outcomes research in a hospital environment.

"We are undertaking radical change."

—William Brody, M.D., Ph.D.

AGGRESSIVE OUTREACH

Clearly, isolation wasn't the answer for the university. In addition to its planned merger with Fairview, it is striving to reach out to

referring physicians and to the business community. Since 1990, the number of university physician visits to communities has more than doubled—from 500 to 1,100 annually, says Theodore Thompson, M.D., pediatrics professor and director of medical outreach. About 12 university physicians participated in 1990; now nearly 60 conduct visits, taking with them university residents and students. The university recently improved physician access by establishing a single phone number to call for referrals and consultations. In addition, it is using video teleconferencing to reach physicians and hopes to use telemedicine to better link emergency rooms in rural Minnesota with the university.

Medical outreach is vital to improving knowledge at both ends. "It's a two-way street—not one-way," says Thompson. "We're learning a lot from physicians." Faculty and students may walk away from a community consult with a new idea for research or a question that needs consideration in current research, he says.

To support its full research agenda, the university must also forge stronger bonds with the outside business community, says Brody. With federal research funds shrinking, leading research institutions are increasingly turning to industry partnerships. Those institutions also have focused their work on areas in which they enjoy a sizable reputation, which tends to attract more dollars. Brody says he envisions the university developing programs of excellence in such areas as molecular genetics, transplantation, and diabetes.

Positioning the Academic Health Center to work on broad social issues also may help it obtain those hard-to-come-by research dollars, says Robert Veninga, QRTC member and head of the Health Management and Policy Division, School of Public Health. By finding innovative and interdisciplinary ways to examine larger community issues, such as violence,



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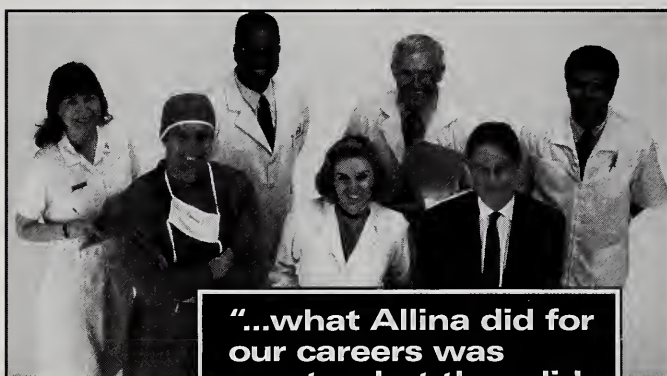


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the Academic Health Center may secure more funds while increasing its value to society, he says.

TO THE FUTURE

Even as the Academic Health Center gets itself back into shape, it will have to keep adapting to change, say reengineering architects. The current shift is away from independent physician practices and toward managed care settings and cost-conscious care provided by interdisciplinary health care teams. Perhaps in the future, physicians will see fewer patients and focus instead on information management and aggregate care—developing the protocols and practices that prove successful.

Such future scenarios make it even more critical for the AHC and its clinical component to reposition itself and work with its communities, says Brody. A university that brings the critical elements of teaching, research, and service together in powerful ways makes a tremendous contribution to society and to the state.

"We are undertaking radical change," Brody told the university regents. "We are the only institution committed at a mission-critical level to the discovery and dissemination of knowledge and using that to improve the health of the citizens. That's what's at stake. That's why this is so important."

MM

Darlene Gorrill is a communications planning and publications specialist in Lauderdale, Minnesota.

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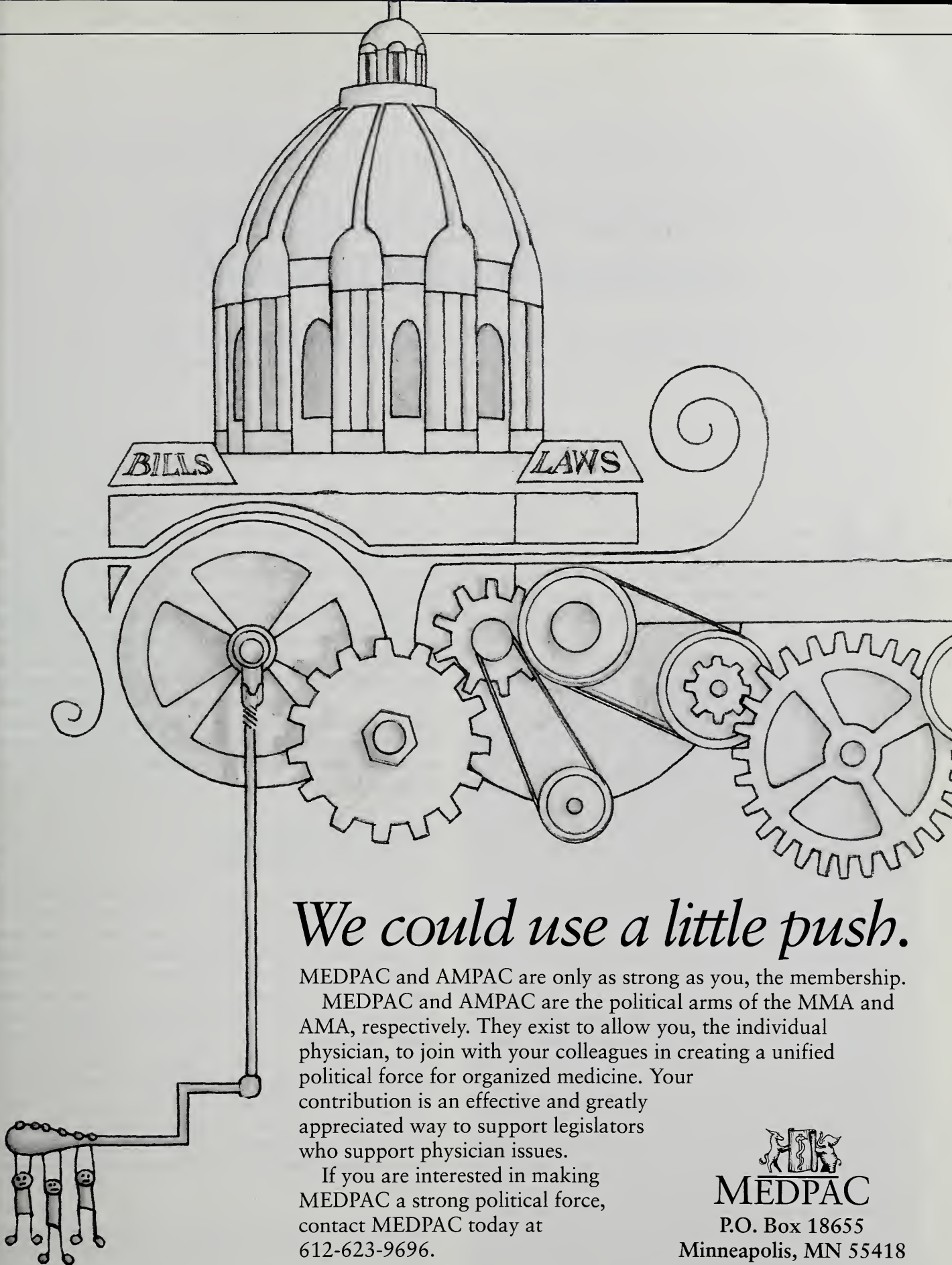
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Current Trends in Financing Graduate Medical Education

Major changes to the financing of graduate medical education can be expected both locally and nationally. How will Minnesota respond?

Janet Silversmith

Minnesota's health system reform efforts were initially aimed at containing costs, expanding access, and improving quality through an economic model of competing integrated services networks (ISNs). Competition would occur on price and quality, and ISNs would be held accountable to both the purchasers and the state. Although the reform model has been altered slightly, competition continues to be the cornerstone of Minnesota's health care delivery system. In a purely competitive model, the inefficient will assumedly fail or cease to be competitive. This is a serious concern for Minnesota's education and research institutions. Can these institutions compete effectively if their costs are naturally higher because of their education and research functions? What is the long-term impact of such competition on the training of Minnesota's health care professionals?

An integrated, managed health care system is intended to create efficiencies in care delivery and resource allocation. Such efficiencies are certain to alter the status quo. According to a report issued by the Pew Health Professions Commission, some of the potential results of health system reform include massive hospital closings; dramatic expansion of primary care provided in ambulatory settings; significant surpluses of physicians, nurses, and pharmacists; and fundamental changes in the scope and structure of medical education.¹

Congressional efforts to balance the federal budget and reduce the growth rate of the Medicare program also portend change in the structure and financing of medical education and research. The plan passed by Congress but vetoed by President Clinton in December would have begun shifting medical education financing away from Medicare. The plan would have established a graduate medical education/teaching hospital trust fund with five separate accounts. Financial contributions would have been from Medicare, as well as from general revenues. In addition, the plan would have limited the number of Medicare-funded residency positions to the level in place as of August 1, 1995; it would have limited residency funding to the first board certification or five years, with

an additional three years for physicians training in geriatric specialties.

Since 1993, the Minnesota Legislature has identified medical education and research as worthy of special consideration, noting that "all health care stakeholders, as well as society at large, benefit from medical education and health care research." The Legislature also has stated that the "cost of medical education and research should not be borne by a few hospitals or medical centers, but should be fairly allocated across the health care system."² This article discusses the financing of medical education* and how Minnesota is preparing for change.

MINNESOTA'S RESPONSE: THE MERC TASK FORCE

To address legislative concerns about the financing of medical education and research in Minnesota, the state health commissioner established an advisory task force of stakeholders, the Medical Education and Research Costs (MERC) Task Force.[†] In 1994, the task force submitted a report to the Legislature creating a framework for reviewing medical education and research needs. A second report in 1995 began to identify the costs and the funding of medical education and research. A third report submitted this legislative session recommends action to address the challenges facing the state's medical education and research activities.

The recommendations call for creating a Medical Education and Research Trust Fund. An advisory com-

*For the purposes of this article, medical education refers to the training of physicians. The Minnesota Department of Health considers medical education the clinical training of physicians, dentists, advanced practice nurses, and physician assistants; the state also defines health care research to include clinical outcomes and health services investigations.

†Much of the data contained in this article is based on the MERC Task Force reports.

mission would assist the health commissioner in distributing the dollars and would continue to study the costs and benefits of medical education and research. Although many details remain to be worked out, the most contentious issue in the recommendations involves the trust fund's source of revenue (an estimated \$20 million to \$25 million). The MERC Task Force did not recommend a funding source, but the commissioner, through the governor's supplemental budget request for Fiscal Year 1997, has requested a general fund appropriation of \$10 million. An additional \$20 million appropriation from the Health Care Access Fund (the fund currently used to finance the MinnesotaCare program) has been suggested for the FY 1998-99 biennium. Legislative support for this request is not strong, and state financing of medical education and research activities will continue to stir significant debate.

MEDICAL EDUCATION IN MINNESOTA

Physician training consists of undergraduate and graduate education. Undergraduate medical education historically has consisted of four years of medical school—the first two years usually spent in the classroom and laboratory, and the second two years in clinical settings. Increasingly, however, undergraduate medical education consists of classroom, laboratory, and clinical work interspersed throughout the entire four years, often occurring in private, outpatient practices.

The United States has 124 medical school programs accredited by the Liaison Committee on Medical Education (LCME), the official accrediting body of educational programs leading to the doctor of medicine degree.^{3,†} Three of these programs are in Minnesota—the University of Minnesota-Twin Cities, the University of Minnesota-Duluth, and the Mayo Medical School. The University of Minnesota-Duluth, accredited for two years of basic medical sciences, is the only program of its type in the United States.

During the academic year 1994-95, there were 45,365 applicants to U.S. medical schools, a 6 percent increase over the previous year; 17,048 were enrolled as first-year students. The growth in medical school applications, combined with relatively constant acceptance rates, suggests a relatively constant, if not increasing, interest in medical school.³

Enrollment in Minnesota medical schools during 1994-95 totaled 1,145 (290 were first-year students). Mayo Medical School had a total enrollment of 162 (42 first-year students); the University of Minnesota-Duluth enrolled 108 students (50 first-year); and the University of Minnesota-Twin Cities enrolled 875 students (185 first-year).⁴

Graduate medical education (GME) is the residency training period after medical school. The length of

graduate medical education has steadily increased since the end of World War II. Before the war, most physicians entered practice after a one- or two-year training period.⁵ Today, a three-year residency is the minimum necessary for any specialty, and up to five years is required for some specialties.

Graduate or residency programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME). As of December 12, 1994, ACGME accredited 7,179 specialty and subspecialty programs nationally.⁶ A total of 97,832 resident physicians were involved in these programs (33 percent of the residents were women).⁶

Graduate medical education in Minnesota, like undergraduate training, occurs in numerous sites, both outpatient and inpatient. It is concentrated, however, in a relatively small number of institutions, often referred to as teaching hospitals. To be eligible for participation in the Council of Teaching Hospitals of the American Association of Medical Colleges, a "major teaching hospital" must sponsor or participate in at least four residency programs.⁵ The teaching hospitals in Minnesota that meet this criteria are the University of Minnesota Hospital and Clinic, Hennepin County Medical Center,

THE MMA'S POSITION

In response to anticipated changes in the financing of medical education, the Minnesota Medical Association created an ad hoc task force, chaired by Diane A. Dahl, M.D. The task force issued a final report in September 1995. The MMA's recommendations addressed both federal (Medicare) issues as well as state issues related to medical education.

The MMA opposes the use of the Health Care Access Fund for purposes other than to support the MinnesotaCare insurance program. It supports the distribution of funds for medical education only to accredited programs, but the dollars should flow to the entity that incurs the costs, whether it's a medical school, hospital, nursing home, or ambulatory clinic.

The MMA believes that the number of first-year residency positions should be reduced to 110 percent of the number of U.S. medical school graduates. Residency allocation decisions should be made only at the national level. Minnesota could, however, continue to influence medical students and medical schools by contributing to loan and scholarship programs; supporting medical school curriculum and activities, such as expanded ambulatory-based and community-based educational experiences; and meeting the ongoing funding needs of academic programs with declining clinical practice plan revenues.

—JS

†This number, correct as of July 1, 1995, is down from 125 the previous July. The change was the result of the merger of the Medical College of Pennsylvania and Hahnemann University School of Medicine.

the Veterans Affairs Medical Center, Saint Marys Hospital in Rochester, Rochester Methodist Hospital, St. Paul-Ramsey Medical Center, and Abbott Northwestern Hospital.⁵ In 1994, Minnesota had 127 programs for GME involving 2,102 resident physicians.⁶

THE ECONOMICS OF MEDICAL EDUCATION

UNDERGRADUATE COSTS

Calculating the clinical training costs of undergraduate medical education is extremely difficult. No standard definitions or reporting formats exist, and, very often, clinical experience is provided in private settings through donations of time and overhead expenses by the supervising physicians. A testament to the difficulty in quantifying total undergraduate medical education costs is the absence of any significant national studies in nearly 25 years.⁸ Using a 1971 Institute of Medicine study, the Minnesota Department of Health, through its MERC Task Force, calculated an average cost for undergraduate medical education in Minnesota of \$45,645 per student per year (1993 dollars).⁷

UNDERGRADUATE FINANCING

Undergraduate medical education is financed through numerous sources. Tuition, always substantial but variable depending on an institution's endowment and class size, represents only a fraction of the revenue necessary to train a medical student. For the 1994-95 academic year, annual resident tuition and fees at Minnesota's medical schools were approximately \$9,925 at Mayo, \$14,650 at the University of Minnesota-Twin Cities, and \$14,680 at the University of Minnesota-Duluth; the non-resident tuition was \$19,800, \$28,742, and \$28,772, respectively.⁴ Many medical students must rely on loans and then face significant future indebtedness. About 80 percent of the 1994 medical school graduates had some form of educational debt, half of them with debt in excess of \$50,000.⁸ The 1994 mean debt for medical school graduates was \$63,434.⁸ Additional sources of medical school revenue include endowments, grants, practice revenue, and public appropriations.

According to data collected by the Minnesota Department of Health, FY93 state funding of undergraduate medical education totaled about \$30 million. The University of Minnesota Medical School received \$28 million in general education appropriations, \$432,000 for the Primary Care Physician Training Initiative from the Health Care Access Fund, and \$889,000 for the Rural Physician Associate Program for third-year medical students. These appropriations, together with students' tuition and fees, represented about 18 percent of the medical school's \$250 million budget for FY93. Other funding sources included medical service revenue (37 percent), research and other sponsored programs

(30 percent), and gifts and other sources (14 percent). The Mayo Foundation received \$682,000 for Minnesota resident medical students (about 40 students in FY93).⁵

GRADUATE MEDICAL EDUCATION COSTS

Graduate medical education occurs in both the outpatient and traditional inpatient setting. Costs in outpatient settings are difficult to determine and are rarely tracked because there is no explicit funding source for ambulatory-based sites. Much of the graduate medical education that occurs in private practices (like undergraduate medical education) is financed through the voluntary contributions of practicing physicians and/or through patient revenue that flows to these settings. The costs of these programs are significant but seldom are incurred by the accredited residency programs.

Traditional graduate medical education based in teaching hospitals is costly. Direct costs include residents' salaries and fringe benefits, supervising faculty salaries and fringe benefits, and support required to maintain training programs, including program administration and classroom space.⁵ Direct costs are, theoretically, readily identifiable and are reported annually by teaching hospitals on Medicare cost reports.

The MERC Task Force identified the total FY93 reported direct GME costs for Minnesota hospitals at about \$119 million.⁵ This figure represents the *reported* costs. Medicare, as the largest payer of medical education, identifies *allowable* costs based on FY84 hospital-specific per-resident costs updated by an inflation factor. The Medicare-allowable medical education costs for FY93 in Minnesota hospitals were \$61 million.⁵ Considerable debate surrounds not only the accuracy and comparability of the reported costs, but also the accuracy and validity of Medicare's method for determining allowable costs. The U.S. Department of Health and Human Services determined that the variation in Medicare's direct payments reflected differences in accounting practices, rather than differences in the true costs of training.⁹ Given the controversy over these figures, MERC formed an ad hoc task force to identify alternative methods for estimating Minnesota's direct medical education costs. The task force's estimate for FY93 total direct GME costs in Minnesota is \$172 million.⁷

Indirect costs refer to the "incremental costs associated with clinical training, including increased use of ancillary services because of residents' inexperience; the tendency to try to make a more accurate diagnosis for educational purposes; the time delay due to oversight and consultation; the decreased productivity of nurses and other employees who have to assist the new residents; and increased record-keeping requirements."⁵ Indirect costs do not include those related to increased case mix complexity.⁵ The intangible nature of many of the incremental costs makes them extremely difficult to calculate.

A study conducted in 1994 to determine the indirect costs incurred at U.S. teaching hospitals revealed a range for total inpatient indirect costs of \$8.3 billion to \$8.6 billion annually.⁵ The method used to calculate indirect

⁸The total cost of undergraduate medical education deserves attention. In a competitive environment, however, the dollars most at risk are those related specifically to clinical training.

costs involved developing a regression equation to estimate the impact of nonteaching and teaching variables on total hospital costs. The same approach, developed by Lewin-VHI, was applied to Minnesota and showed a range of costs from \$46 million to \$118 million.¹⁰ The MERC committee reviewed the Lewin-VHI data but decided that the wide-ranging estimate could not be used to determine Minnesota's indirect costs with any degree of accuracy.

FINANCING

Graduate medical education has largely been financed through the patient care revenues generated by hospitals.⁹ The private sector (i.e., employers and health insurers) has historically contributed to the costs of GME by reimbursing teaching institutions' higher charges. In a highly competitive health care environment, however, private payers may tend to choose lower-cost facilities that offer comparable quality. This potential revenue loss is a threat to medical education and represents the dollars that Minnesota seeks to capture in a new financing arrangement.

Although the private sector has helped finance medical education, the federal government is the largest explicit source of financing, contributing funds to cover 40 percent of medical education's direct expenditures in 1991.⁵ Medicare is the single largest documented source of graduate medical education financing, covering 29 percent of all expenditures in 1991.⁵

Medicare funds medical education through direct medical education (DME) payments and an indirect medical education adjustment (IMEA). Medicare payments for graduate medical education are generally only available to teaching hospitals and do not support substantial training in ambulatory settings. In 1992, Medicare paid \$1.6 billion nationally for DME.⁵ DME payments are projected to surpass \$2 billion in 1996.¹¹

Minnesota hospitals in FY93 received \$23.7 million in direct medical education payments from Medicare. Note, however, that this contrasts with the reported costs (\$119 million on Medicare cost reports) and with MERC's refined cost estimate (\$172 million).

Medicare's Indirect Medical Education Adjustment is a hospital-specific add-on to the hospital's Diagnosis-Related Group reimbursement rates. The IMEA is not the corresponding payment to indirect costs; it was not created as an additional means of support for the teaching function. Rather, the IMEA was developed to compensate teaching hospitals for their increased costs "associated with the presence of an educational program that could not be attributed to resident and attending physician salaries, the greater complexity of care provided in teaching hospitals due to the generally higher severity of illness of the patient population, and the uncompensated care that is provided that could no longer be supported through some cost shifting to Medicare patients."¹¹ National IMEA payments are projected to reach nearly \$4 billion by 1996.¹¹

Minnesota hospitals received about \$88 million in IMEA payments in FY93.⁵ Total Medicare payments for

GME in FY93 in Minnesota totaled more than \$112 million or about \$82,000 per-eligible-resident per year, compared with the national average per-resident payment of about \$70,000.⁵

States also contribute to GME. Minnesota in FY93 contributed nearly \$13 million to training physicians: \$274,000 to the Mayo Medical Foundation for grants to family practice residents; \$96,000 from the Higher Education Coordinating Board for the rural physician loan repayment program; \$1.8 million for the University of Minnesota's Primary Care Physician Initiative; and about \$10.8 million to the university for the hospital education offset of the health sciences special appropriation.⁵

THE PHYSICIAN WORKFORCE

A discussion of medical education would not be complete without touching on the workforce it produces. In a more competitive health care market, it is possible that economic forces alone will create an appropriate supply and specialty mix of physicians, rendering government involvement unnecessary. Market forces may trigger a reduced demand for physicians; however, teaching hospitals, attempting to remain competitive, may continue to have an incentive to recruit and train the relatively less-expensive residents, particularly those in specialty fields.⁵ Nationally, the number of nonfederal, active physicians has grown at a faster rate than the general population. In 1970, there were 153 physicians per 100,000 population; by 1993, the figure had increased to 252 per 100,000.⁵ An ideal ratio has not been fully endorsed; but notably, a physician-to-population ratio of one per 3,500 population (about 29 physicians per 100,000 population) is used to identify federal Health Professional Shortage Areas.

In 1993, approximately 13,913 physicians had active licenses in Minnesota (they were not necessarily actively practicing).¹² The Minnesota physician-to-population ratio of 255 per 100,000 population in 1992 was slightly higher than the national ratio of 248.⁵

Projections of the physician workforce indicate that by the year 2020, the national physician-to-population ratio will increase by more than 25 percent.⁵ Sophisticated projection models have been developed, including need-based models, demand-based models, and HMO staffing models.¹³ Although the approaches differ, the conclusions are similar—the supply of physicians will exceed the predicted need in the year 2000 by about 70,000 to 163,000 physicians.⁵

Recommended solutions to alleviate this projected glut are often controversial and viewed with skepticism. The Pew Health Professions Commission, for example, recommended a 20 percent to 25 percent reduction in the size of the medical school class entering in 2005 to be accomplished through the closings of medical schools, not simply an across-the-board reduction in enrollment.¹

¶The hospital education offset is used to offset some of the indirect costs associated with residency programs and, therefore, is similar to Medicare's Indirect Medical Education Adjustment.

Needless to say, academic medicine argues that such an approach is inappropriate.

The bulk of workforce discussions are focused on workforce composition—specialists and generalists (i.e., primary care physicians). There is considerable evidence that too many specialists are being trained. In 1992, about 33 percent of all actively practicing physicians were generalists; in 1960, 50 percent of physicians were generalists.⁵ However, there may be some change in this trend. The 1995 National Residency Matching Program reported that 51 percent of senior medical students were seeking positions in generalist fields, and in 1994, family medicine recorded a 13 percent increase in filled positions over 1993.¹⁴

Concern about the oversupply of specialists has spurred proposals to artificially segment the types of physicians into a 50-50 primary/specialty split. Although this composition is similar to the physician mix found in other Western industrialized nations, there is no empirical evidence to support this makeup as appropriate.¹⁵ Proposals that seek to achieve this 50-50 mix raise two fundamental questions: What evidence exists to support 50 percent as the correct number, and what is the definition of primary care?¹⁵ Clearly, the more broadly primary care is defined, the sooner the 50 percent policy goal could be met. Proposals of this kind have sparked intense efforts by many specialty societies to gain designation as primary care providers. Most notably, the federal government has included ob/gyn with the traditional primary care fields of family practice, internal medicine, and general pediatrics when identifying Health Professional Shortage Areas.

Excluding residents, Minnesota has approximately 78.6 physicians per 100,000 population in primary care (family practice, internal medicine, general practice, pediatrics) and 118.2 specialists per 100,000 population; nationally, the figures are 67 and 117, respectively.¹²

Currently, approximately 17,000 students graduate each year from U.S. schools granting M.D. and D.O. degrees; meanwhile, about 25,000 entry-level residency positions are available. The number of positions exceeds the number of U.S. graduates by more than 40 percent.¹¹ The remaining positions are generally filled by international medical graduates (IMGs). Since 1990 the percentage of medical residents who are IMGs has been increasing.¹⁴ In 1994, 24 percent of all residents were IMGs. Efforts to alter the size and composition of the physician workforce through market forces alone often neglect the issue of IMGs.

An increasing proportion of IMGs (38 percent in 1994) enter the United States on exchange visitor visas (nearly 50 percent of all IMGs are either U.S. citizens or permanent resident aliens and, therefore, are unaffected by changes in immigration policy).⁶ Exchange visitor visas require physicians to return to their home country for at least two years after completing training before re-entering the United States. As a result of the Immigration and Naturalization Amendments of 1993, state health departments may now request a waiver of this require-

ment for physicians agreeing to practice in underserved areas for at least three years.¹⁴ (Previously, only federal agencies could request these waivers.) The impact of this change is not clear, but it may increase the number of exchange visitor visas granted.

Several recommendations have been advanced for slowing the growth of physician supply, including limiting the number of first-year residency positions and reducing the class size of medical schools. Limiting residencies is the most commonly discussed approach, given its potential impact on overall physician supply and training costs.

If residency positions are reduced, determining where to make cuts is an issue. Across-the-board cuts at the state level would not be equitable given the substantial geographic variation in the number of residents trained per 100,000 population; the national average is 35 per 100,000 population, but Alaska, Idaho, and Montana have none; Massachusetts has 62, and New York has 74.¹⁵ Minnesota has approximately 48 residents per 100,000 population.⁶

The most serious debate will ultimately focus on what residency positions should receive federal dollars. Numerous possibilities have been discussed, including selection based on geographic distribution, minority representation, record of placing graduates in rural and underserved urban areas, and on the basis of educational quality.¹⁵

CONCLUSION

Minnesota's health care industry is an integral component of the state's economy, employing about 190,000 people and generating roughly \$15 billion in annual gross state product.⁵ Minnesota has unparalleled pride in its academic and research institutions and has been at the forefront of medical breakthroughs. The continued success of the state's medical education infrastructure is critical to ensuring a well-trained workforce and a healthy population.

MM

Janet Silversmith is a health policy analyst at the Minnesota Medical Association. She has a master's degree in policy analysis from the University of Minnesota's Humphrey Institute of Public Affairs. This article includes information compiled in a September 1995 report by the Minnesota Medical Association Ad Hoc Task Force on Medical Education. For a copy of the report, call Janet Silversmith at 612/378-1875.

REFERENCES

1. Pew Health Professions Commission. Critical challenges: revitalizing the health care professions for the twenty-first century. San Francisco, California: UCSF Center for the Health Professions, 1995.
2. Minnesota Statutes 62J.045, subd. 1.
3. Barzansky B, Jonas H, Etzel S. Educational programs in U.S. medical schools, 1994-1995. JAMA 1995;274(9):716-22.
4. Medical schools in the United States [Appendix IA, Tables 1 and 2]. JAMA 1995;274(9):745-52.
5. Minnesota Department of Health. Medical Education and

Research Costs (MERC) report. Minneapolis: Minnesota Department of Health, March 1995.

6. Graduate medical education [Appendix II, Tables 1 and 2]. JAMA 1995;274(9):755-62.

7. Minnesota Department of Health. Medical Education and Research Costs (MERC): a final report to the Legislature [Draft]. Minneapolis: Minnesota Department of Health, February 1996.

8. Ganem J, Beran R, Krakower J. Review of U.S. medical school finances, 1993-1994. JAMA 1995;274(9):723-30.

9. Physician Payment Review Commission. Annual report to Congress. Washington, D.C.: Physician Payment Review Commission, 1993.

10. Dobson A, Coleman K. Analysis of inpatient IME costs in the state of Minnesota. Minneapolis: Minnesota Department of Health, 14 March 1995.

11. American Medical Association. Transforming Medicare. Chicago: American Medical Association, June 1995.

12. Minnesota Department of Health, Office of Rural Health and Primary Care. A summary of practice related data: Minnesota physicians. Minneapolis: Minnesota Department of Health, June 1994.

13. Weiner JP. Forecasting the effects of health reform on U.S. physician workforce requirement. JAMA 1994;272:222-30.

14. Physician Payment Review Commission. Annual report to Congress. Washington, D.C.: Physician Payment Review Commission, 1995.

15. Physician Payment Review Commission. Annual report to Congress. Washington, D.C.: Physician Payment Review Commission, 1994.

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ANNOUNCEMENTS

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MMA OFFERS PAYERS PERSPECTIVE WORKSHOPS

The Minnesota Medical Association announces its 1996 Payers Perspective Workshops. The workshops will be held from 9 a.m. to 3:30 p.m. on the following dates:

Tuesday, April 16—St. Paul
Thursday, April 18—St. Paul
Tuesday, April 23—Duluth
Thursday, April 25—St. Cloud

The registration fee is \$90 for each registrant. For more information, call Vicki Westling at the MMA, 612/378-1875 or 800/999-1875.

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INFORMATION ABOUT LEGISLATION

To find out the status of a particular bill at the Minnesota Legislature, call the House Index, 612/296-6646, or the Senate Index, 612/296-2887. It helps to have the bill number, but it isn't necessary.

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HOW TO CALL YOUR LEGISLATOR

If you would like to express your opinion on a particular bill, you may call the office of your senator or representative, state your position on the bill, and possibly give a brief reason for your support or opposition. The staff member will record your opinion and thank you. Legislators do pay attention to their phone calls.

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PLAN TO ATTEND THE MMA ANNUAL MEETING

The Minnesota Medical Association's 1996 Annual Meeting will be held at the Northland Inn in Brooklyn Park, Wednesday, September 18, to Friday, September 20, 1996. Mark your calendar now!

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Bills Are Moving Forward at the Legislature

The rush to meet committee deadlines is over and the 1996 Minnesota Legislature is on schedule to adjourn by mid-April. For the first time in several years, there is no major health reform bill, but many smaller bills could have an important impact on health care delivery.

So far, the MMA is doing well in meeting its goals for the session. The MMA has successfully opposed bills that would give advanced practice nurses independent prescribing authority and would allow chiropractors to perform truck drivers' physical examinations. MMA-supported bills are moving forward, including bills regarding a point-of-service option, a ban on exclusive contracts, improvements in growth limits, 48-hour postpartum stays, youth access to firearms, youth access to tobacco, and release of medical records for research.

The situation is still fluid. Bills that have not met committee deadlines could still be resurrected in the form of amendments. Changes can take place rapidly on the floors of the House and Senate.

Nurse Prescribing Bill Fails

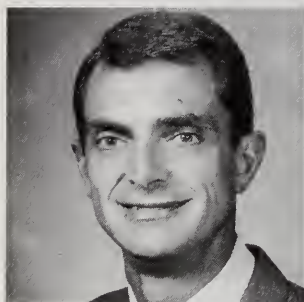
Thanks to a strong grassroots effort, the MMA has blocked a bill that would have given advanced practice nurses unlimited authority to prescribe drugs, as well as broad powers to practice medicine. The bill, H.F. 2444-Cooper/S.F. 2133-Hottinger failed to receive a hearing in either the House or Senate.

Under present law, advanced practice nurses are able to prescribe medications under the delegated authority of a physician. The MMA supports this collaborative relationship between physicians and advanced practice nurses who work together to develop written protocols setting the extent of the nurse's authority to prescribe.

The MMA has been meeting with the Minnesota Nurses Association and with the chief authors of the bill to discuss administrative problems that nurses have with the existing delegated prescribing law. The MMA has agreed to support the nurses' proposal to repeal a requirement that the written agreement between the physician and nurse must be filed with the Board of Nursing. The MNA is expected to seek an amendment that would allow the agreement to be on file at the practice site.

Point-of-Service Bills Go to the Floor

The MMA initiated a bill, H.F. 2389-Huntley/S.F. 2023-Hottinger, that would require each health plan in Minnesota to offer a point-of-service product in the individual, small-group, and large-group markets. The plans would have to submit the premium rates and cost-sharing requirements to the commissioner of commerce or the commissioner of health for approval. The bills are awaiting action on the House and Senate floors. See pages 35 to 39 for more legislative articles. • • • • •



Viewpoint

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Michael J. Murray, M.D.
President, Minnesota Medical Association

Where Do Allied Health Professionals Fit In?

Allied health professionals are playing an increasing role in the delivery of health care. Thanks to telemedicine, physician assistants (PAs) and advanced practice nurses (APNs) are able to provide health care in rural areas and, at the same time, draw upon the expertise of physicians to help with complex diagnoses. As pressures to be cost-effective mount, many clinics are turning to APNs and PAs to deliver routine care and are using physicians only for more difficult cases. The success of these arrangements depends on a close working relationship between the physician and the allied health professional.

Ideally, physicians and the allied professionals complement one another, working together for the benefit of the patient. We're on the same health care team. But occasionally disagreements arise.

For years, groups of allied and alternative health professionals have pressured lawmakers to expand their scope of practice. This session, the advanced practice nurses proposed a bill that would have allowed them to prescribe any drug—independently and without restriction. In addition, the chiropractors continued to promote a bill, introduced last year, that would authorize them to perform the physical exams that federal law requires truck drivers to have every two years. This pressure for inde-

pendence threatens to erode the overall quality of medical care and to undermine the collaborative relationship that should exist between physicians and allied health professionals.

The collaborative model set up in current law works well. APNs must have a signed agreement with a physician that outlines their prescribing privileges and gives them authority to order lab tests, x-rays, or physical therapy.

A successful example of collaboration is the APN clinic that the Mayo Clinic set up in Kenyon, a rural community 15 miles from the closest physician. The APN spends time with patients, answering their questions and advising them about preventive medicine. He is linked by telemedicine to Mayo physicians so that he can ask for help in diagnosing difficult cases. A special exam room is equipped with a camera, electronic stethoscope, and otoscope, as well as the equipment to transmit EKGs and x-rays to Mayo. The APN handles most cases on his own, but a physician electronically supervises care and is available for consultation.

Currently, the MMA is engaged in discussions with the Minnesota Nurses Association that we hope will preserve such collaborative working arrangements with APNs and at the same time address nurses' concerns about the way the system is working.

Physician assistants are another important member of the health care

team. Licensed by the Minnesota Board of Medical Practice, PAs practice under the supervision of a physician. The PA and the supervising physician sign an agreement specifying the PA's scope of practice and the type of supervision. As a group, PAs are content with this collaborative arrangement. The presence of PAs is increasing in Minnesota. Augsburg College recently established a two-year PA program. Physicians who wish to assist in the education of PAs, or who would like more information about PAs, should call the Augsburg program at 612/330-1039.

Working with physicians, APNs and PAs may provide a more holistic approach to health care. They can concentrate on preventive medicine and follow-up care, leaving the physician free to focus on more complex cases. APNs and PAs may also fill a need in rural and underserved areas. But when a patient has a health problem that isn't easy to identify, a physician should be available for consultation. The number of years we spend preparing for our profession gives us a depth of knowledge that most allied health professionals do not have. We are aware of more possibilities.

If health care is to be safe and effective, the providers' responsibilities must be commensurate with their education and experience. The MMA has resisted the attempts of non-physician health care providers to gain authority to provide care they are not trained to give. Chiropractors, for instance, have tried for two years to pass a bill that would allow them to perform truck drivers' mandatory physical examinations. The MMA argued successfully that chiropractors are trained to help patients with low back pain by using spinal manipulation; they are not trained to conduct physical examinations or to provide primary care.

High-quality care requires a team approach. Providers should give only the care they are trained to give, and physicians should be ultimately responsible for supervising and coordinating the health care of patients.

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Youth Access to Firearms Bill Advances

The MMA's bill to require firearms to be unloaded and locked when stored in homes where there are children under age 18 is on its way to the floor of the Senate, while a weakened version of the bill heads to the House floor as part of the Omnibus Crime Bill.

Senate Crime Prevention Committee Passes Firearm Bill

After moving testimony by a mother who lost her son and by young people who lost their friends in unintentional shootings, the Senate Crime Prevention Committee passed the bill, S.F. 2328-Ranum, on a voice vote February 7. Testifying for the MMA, Cheryle Matis of Plymouth told lawmakers that her son Brandon, age 15, was killed by a 15-year-old friend who had found his father's gun in a drawer. Believing the gun was unloaded, the friend played with the gun and it went off, killing Brandon. Matis pleaded with legislators to pass a law that would protect other families from losing a child. "This does not ban firearms or take away firearms; it does say you need to be responsible," she said.

Also testifying for the MMA, John Darby, age 15, told lawmakers that he had been playing with a firearm that he believed was not loaded when the gun went off, firing a bullet through a closed door. When Darby opened the door he saw a man lying on the ground in a pool of blood, his ankle shattered.

The young people stressed the fascination of guns. They told lawmakers they wouldn't be able to resist taking a gun out and playing with it if it were easily accessible in their homes.

Sen. Allan Spear, DFL-Minneapolis, chair of the Crime Prevention Committee, said that current law set age 14 as the age when reasonable precautions are required because lawmakers believed that young people older than 14 would be able to find

the keys and unlock the guns anyway.

"I sure can't find my Dad's car keys," 17-year-old Heather Miller of St. Cloud told Spear. "If Dad put a gun lock key on his key ring, I'd never get it."

Replying to the bill's opponents' assertion that education, not regulation, is the key to gun safety, Sen. Jane Ranum, DFL-Minneapolis, held up the MMA's "Unload It and Lock It" brochure and said that the MMA was placing this brochure in physicians' offices to educate the public. "We agree that education is important," Ranum said, "but it is not enough." She pointed to the rising number of successful teen suicides. One study found that 91 percent of suicide attempts with guns were successful, compared with 23 percent with poison and 4 percent with knives.

On behalf of the MMA, Jeffrey Schiff, M.D., an emergency pediatrician, submitted written testimony, showing that 360 young people in Minnesota lost their lives because of gunshot wounds between 1990 and 1994. Many of these deaths could have been prevented if the firearms had been unloaded and locked. The MMA bill was endorsed by Attorney General Hubert H. Humphrey III, Minneapolis Mayor Sharon Sayles Belton, the Minnesota Chapter of the American Academy of Pediatrics, the Minnesota Chapter of the American College of Emergency Physicians, and many safety groups.

Judiciary Committee Weakens Firearm Bill

The House Judiciary Committee seriously weakened the House bill by deleting the provision calling for firearms to be unloaded and locked. "This guts the bill," said Mark Vukelich, director of the MMA Department of Communications. "We'll continue to fight for the Senate version of this bill that defines how guns

Call for Firearm Safety Brochure

• • • • • THE MINNESOTA Medical Association has developed the brochure, "Unload It and Lock It," which includes "Your Physician's Firearm Safety Checklist," and strongly urges people to unload and lock their stored firearms. To obtain brochures for your patients, call Beth Hoheisel at 612/378-1875 or 800/999-1875. The brochure can also be used as a poster in your waiting room.

must be stored in homes with children. They must be unloaded and locked up, not tucked underneath a mattress or shoved in a drawer."

Like the Senate bill, the House bill would raise the age when current law requires that guns be stored with "reasonable caution" from age 14 to 18. Statistics show that there are three times as many firearm deaths in the 15 to 18 age group as there are in the birth to age 14 range. A. Stuart Hanson, M.D., testified for the MMA before the Judiciary Committee, stressing that gun violence is a health epidemic for young people.

Responding to the Gun Owners Civil Rights assertion that the MMA bill could lead to warrantless searches of homes by armed police and health care workers, the Judiciary Committee accepted St. Paul DFL Rep. Howard Orenstein's amendment that makes it clear there would be no administrative searches to determine whether families were complying with the law. The committee folded the amended proposal into the Omnibus Crime Bill, which is on its way to the House floor.

The MMA is urging legislators to support the Senate version of the bill, which calls for the age increase and makes it clear that storing a firearm with reasonable caution means unloading and locking it. In both versions of the bill, violation of the law would remain a misdemeanor.

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Weakened Youth Access to Tobacco Bill Goes to Floor

A bill, S.F. 558-Jennings, to enforce the law against selling tobacco to children is heading to the House floor, but it has been so weakened by tobacco industry amendments that many of its former supporters may oppose it.

A strong bill passed the Senate last year that for the first time would set penalties for store owners as well as for clerks and minors who violate the law against selling tobacco products to minors. In addition, the bill would require all clerks who sell tobacco to be educated about tobacco sales laws and the penalties for violation.

Tobacco Industry Wins Preemption Clause

This session, however, the House Commerce Committee amended the bill to prohibit local communities from enacting stronger tobacco sales

ordinances than the state's. The tobacco industry pushed hard for this preemption clause so it would not have to fight every local community's efforts to protect children from a lifetime of nicotine addiction. The amended bill also exempts retailers from penalties if they can show they provided training for their salespersons. This loophole would make it virtually impossible to hold retailers accountable for illegal tobacco sales to minors.

At a news conference February 15, Rep. Ann Rest, DFL-New Hope, announced that she will propose an amendment on the House floor that would remove the preemption amendment and preserve local control. As amended, the House bill would block current efforts by at least 15 cities, including Bemidji, Detroit Lakes, Plymouth, and Minnetonka, to develop tobacco sales

ordinances. It would, however, allow existing local ordinances to remain in place. Cities including Chanhassen, Litchfield, and Roseville have enacted strong laws that are working to curb teenage tobacco purchases.

Preemption is the tobacco industry's No. 1 national strategy, according to Peter Fisher, state policy coordinator for the national Coalition on Smoking OR Health. Fisher distributed a leaked memo from former tobacco lobbyist Victor L. Crawford, which read, "We (tobacco lobbyists) could never win at the local level. So (our) first priority has always been to preempt the field ... because the health advocates can't compete with me on a state level." Fisher commented, "Money and influence work better at the state level than at the local level."

MMA Supports Local Control

The MMA, along with other members of the Smoke-Free Coalition, strongly supports efforts to remove the preemption clause. A. Stuart Hanson, M.D., president of the Smoke-Free Coalition, told reporters, "We are here in a battle for the hearts and minds and nicotine receptors of our children. If we don't prevent our youth from starting to smoke, tobacco will eventually kill them."

Karen Anderson, mayor of Minnetonka and president of the League of Minnesota Cities, said no bill at all would be better than a bill with the preemption clause.

The bill is waiting to be heard on the House floor, where Rest will try to remove the preemption clause. If her attempt fails and the bill passes the House with the preemption amendment, the differences between the House and Senate bills would be worked out in conference committee. The Senate bill has no preemption clause.

State Could Lose Money if Kids Buy Tobacco

..... ATTORNEY GENERAL Hubert H. Humphrey III has warned that unless Minnesota prevents children from illegally purchasing tobacco products, the state could lose a significant amount of federal funds under the final regulations issued by the U.S. Department of Health and Human Services to implement the Synar Amendment, a 1992 federal law. This law prohibited the sale of tobacco to children under age 18 and required DHS to develop rules to implement the law. The recently issued rules require every state to set a goal of reducing the frequency with which children are

able to buy tobacco illegally and to develop a plan to meet that goal. States must conduct random checks to see if the laws banning tobacco sales to children are being followed. If the goals are not met, the state could lose up to 40 percent of its federal substance abuse block grant.

Humphrey supports the MMA-backed Youth Access to Tobacco bill, which would put teeth in the law against selling tobacco to minors. This bill passed the Senate last year, and a weaker version of the bill with a preemption clause is headed for the House floor.

Postpartum Bill Moves Forward

Bills to require health plans to cover at least 48-hour hospital stays following vaginal delivery and 96-hour stays following a cesarean section are moving quickly through the Legislature. Nancy Baker, M.D., a family physician at St. Paul-Ramsey Medical Center, testified on behalf of the Minnesota Medical Association and the Minnesota Academy of Family Physicians in favor of the postpartum coverage bill, S.F. 1791-Betzold, before the Senate Commerce Committee. "In order to assure optimal maternal and newborn well-being," Baker said, "it is critical that physicians retain the ability to determine the appropriate length of stay for the mom and baby free of undue pressures from health plans, third-party payers, and hospitals," Baker said.

In the hearing before the Senate Health Care Committee, some legislators questioned whether they should be involved in making decisions about length of hospital stay. "We are not the font of all wisdom. You shouldn't depend on us to define good medical care," said Sen. Don Kramer, IR-Brooklyn Center.

Doris Brooker, M.D., a member of the academic and clinical staffs of the University of Minnesota Laboratory Medicine, Pathology, and Obstetrics and Gynecology departments and a member of the Minnesota Board of Medical Practice, agreed that in general it is hard to practice medicine legislatively. "But the BMP is seeing real compromises in maternal care," Brooker said. "Money is the basis of this policy, not good care. There are five to 10 maternal deaths a year. Out of 5,000 pregnancies there are 600 or 700 mothers who have serious postpartum problems and require hospitalization."

The bill's provision specifying who decides when the mother should go home has been changed by various amendments in the Senate bill. Currently, as amended by the Senate Health Care Committee, the mother and the physician together would

decide whether the mother needed to stay at least 48 hours for a vaginal delivery and 96 hours for a C-section. If they decide she could go home earlier, insurance would have to cover a nurse home visit within four days. The amended bill is on its way to the Senate floor.

The House bill, H.F. 2008-Opatz,

with the original language requiring a physician in consultation with the mother to determine whether the longer stay was medically necessary, passed the House floor February 1 on a 126-8 vote.

The MMA supports both the House and Senate versions. Differences in language would have to be worked out in conference committee. ♦ ♦ ♦ ♦ ♦

MinnesotaCare Laws May Be Improved

The MMA is pushing a number of proposals that would improve MinnesotaCare legislation.

Extend Exclusive Contract Ban

The ban on exclusive contracts, currently scheduled to sunset in 1997, would be extended to the year 2000 by the bill H.F. 2624-Cooper/S.F. 2272-Sams. The ban was passed in 1994 at the urging of the MMA so that health care providers would be free to negotiate contracts with many different health plans. The law was intended to protect providers from pressure to sign exclusive contracts.

Repeal Growth Limits

State growth limits would not be enforced, but would become "cost-containment goals" under an amendment to the House version of the bill, H.F. 2624-Cooper, which was proposed by Rep. Thomas Huntley, DFL-Duluth, and adopted by the MinnesotaCare Division of the House Health and Human Services Committee. The amendment would repeal the Minnesota Department of Health's authority to enforce the growth limits, but would still require physicians and other health care providers to submit cost-containment information to the MDH so that the overall costs of health care in Minnesota could be monitored. Growth limits were adopted three years ago to reduce the growth of health care

spending, but support for them has eroded even within the MDH because of the difficulty of enforcing them. The Senate companion bill does not include the repeal of the growth limits, and the bill's author, Sen. Linda Berglin, DFL-Minneapolis, has said she will not try to move the bill in the Senate if a repeal amendment is added.

The bills are awaiting action on the House and Senate floors.

Repeal CPI-U Change

Although Berglin opposes repealing the growth limits, she has proposed an improvement. Last year the Legislature changed MinnesotaCare law so that physicians who comply with the state growth limits by limiting their fees are subject to a growth limit based solely on the regional consumer price index for urban consumers (CPI-U). If they limit revenue per patient or revenue per encounter, however, they can apply the full growth limit of CPI plus X percent. (The X factor is set by law to reflect increases in volume and intensity.) Berglin's proposal would repeal the change and allow physicians to use the full growth limit regardless of how they comply with the growth limits. The proposal has been amended to H.F. 2190-Cooper, which includes technical changes to MinnesotaCare law. ♦ ♦ ♦ ♦ ♦

LEGISLATIVE NEWS

CHIROPRACTORS' BILL FAILS

The MMA has apparently once again blocked the chiropractors' attempt to pass a bill that would allow them to perform the physical exams that truckers are required to have every two years. The bill was proposed last year after the Minnesota Department of Transportation stated that a physical examination performed by a chiropractor does not satisfy the federal requirement for truck drivers' exams.

The bill stalled in the Senate Health Care Committee last year, but this session, its House companion bill passed the House Transportation Committee over strong MMA objections. Before passing the bill, the committee amended it to allow advanced practice nurses as well as chiropractors to perform comprehensive physicals. The amended House bill was referred directly to the House floor, bypassing the Health Committee.

In the face of strong MMA opposition, however, the bill was not heard in the Senate and failed to meet the committee deadline. The MMA told lawmakers that chiropractors have neither the training nor the experience to perform an adequate exam. At least 87 percent of chiropractic patients are seen for musculoskeletal complaints. Physicians, however, treat patients with a wide range of systemic diseases. They are able to determine the subtle signs of diseases such as diabetes or alcoholism.

BILL WOULD RAISE REIMBURSEMENT, EXPAND ELIGIBILITY

The bill, H.F. 2312-Cooper, to expand MinnesotaCare eligibility for single people with no children from 125 percent to 150 percent of the federal poverty level was amended to increase provider reimbursement for MinnesotaCare services by 15 percent. The bill, which would take effect June 30, 1996, would allow

single adults earning \$11,205 or less and families without children earning \$15,045 or less to participate in the MinnesotaCare program. (Currently, single adults are ineligible if they earn more than \$9,338, and households without children are ineligible if they earn more than \$12,538.) According to the Minnesota Health Care Commission, the MinnesotaCare program has resulted in 4,100 fewer Minnesota families receiving Aid to Families with Dependent Children, reaping a net savings of \$24 million annually for the state and federal governments.

The amendment to the bill specifies that if the state runs into budget difficulties, the 15 percent provider increase would be cut. An amendment failed in the Finance Division that would have reduced the 2 percent tax on health care services to 1.25 percent. Opponents argued that it would result in a deficit in the Health Care Access Fund.

The bill passed the House MinnesotaCare division.

In the Senate, the Health Care Committee approved the companion bill, S.F. 1873-Berglin, to expand eligibility to 150 percent, but there is no provision to increase provider reimbursement. This bill was sent back to the Finance Committee.

MEDICAL RECORDS SUNSET BILL ADVANCES

An important bill for research institutions in Minnesota would eliminate the sunset on a provision allowing medical records to be used for research purposes. In the Senate, the bill, S.F. 1966-Ranum, passed out of the Judiciary Committee with an amendment requiring that patients be notified that their records may be released for research purposes and giving them an opportunity to object.

In the House, the MMA successfully

urged legislators to remove an amendment to the companion bill, H.F. 2337-McGuire, that would have required patient consent for the release of medical records after July 1, 1997. After the MMA and others argued that this would stifle research, the bill was amended to require that after July 1, 1997, patients must be notified in writing that their records may be released and that they may object. The House bill was folded into the Omnibus Data Practices Bill.

The bills await action on the House and Senate floors.

PRESCRIPTION DRUG BILL FALTERS

A bill that would allow the commissioner of administration to negotiate prices for prescription drugs sold in Minnesota passed the Senate but failed to meet the committee deadline in the House. Provisions in the bill are expected to be offered as an amendment to other legislation in the House. This proposal, S.F. 410, introduced by Sen. John Marty, DFL-Roseville, would set up a voluntary drug purchasing pool and would require health plans to disclose their prescription drug prices. Last year, Marty introduced a more ambitious bill that would have set up a statewide formulary for all prescription drugs regardless of the payer. The 1995 bill encountered vigorous opposition from the MMA and other groups.

BILL TO CRACK DOWN ON ER VIOLENCE ADVANCES

A bill to toughen penalties for assaults on emergency medical personnel and hospital emergency room staff is on its way to the Senate floor. The bill, S.F. 1968-Beckman, would raise the penalty from a gross misdemeanor to a two-year felony.

LEGISLATIVE NEWS

PRIOR AUTHORIZATION BILL IS PULLED

Legislation that would require all health plans to use physicians licensed in Minnesota to make prior authorization decisions passed the House but was pulled in the Senate by bill author Sen. Pat Piper, DFL-Austin. The bill, S.F. 110-Piper/H.F. 227-Leppik, was supported by the Minnesota Board of Medical Practice and opposed by plans that contract for prior authorization in other states.

The question of whether only Minnesota licensed physicians should make prior authorization decisions has been a controversial one for the MMA. Many physicians believe the requirement that a Minnesota physician perform the review is essential, but others argue that it is not important where the physician is licensed as long as the prior authorization criteria have been developed by actively practicing physicians.

The MMA Executive Committee voted to oppose the bill out of concern that if all the other states adopted similar legislation, physicians making prior authorization decisions would have to be licensed in 50 different jurisdictions. Because of member disagreement on this issue, however, the MMA Board of Trustees reversed the Executive Committee decision and voted to take no position on the bill. The board decided instead to set up an ad hoc committee, co-chaired by C. Randall Nelms, M.D., and Richard B. Tompkins, M.D., to consider the issue and its relationship to interstate health care delivery and telemedicine. Now that the author has pulled the bill, decisions may be put off until next year.

MANDATORY COVERAGE BILLS ADVANCE

The House Financial Institutions and

Insurance Committee on February 7 approved bills that would require health plans to cover screening for prostate cancer, treatment for Lyme disease, and health care for victims of domestic abuse.

The PSA bill, H.F. 2394-Tomassoni, would require insurers to cover the prostate specific antigen test for all men over age 50 and for those men over age 40 who have symptoms or are considered at high risk for the disease. The bill's author, Rep. David Tomassoni, DFL-Chisholm, said that the PSA test was too important to be denied to anyone.

The Lyme disease bill, H.F. 219-Murphy, would require insurance plans to cover treatment for diagnosed Lyme disease cases. The disease can have serious symptoms including chronic arthritis and neurological impairment.

The bill, H.F. 2344-Long, would prohibit insurance companies from using domestic abuse as a reason to deny life or health insurance.

All three bills now go to the House floor.

BILL WOULD REQUIRE REVIEW OF MANDATED BENEFITS

The Senate Health Care Committee passed a bill that would require the commissioner of health to review any request to mandate another health care benefit before it goes to the Legislature for consideration. This proposal, S.F. 2311-Kiscaden/H.F. 2646-Cooper, comes in response to an increasing number of requests that the Legislature require insurers to cover certain health care benefits. Last year, there was an emotional debate over mandating bone marrow transplants for breast cancer. This year there are bills that would require insurers to cover at least 48 hours of postpartum care, to cover treatment for injuries caused by domestic violence, and to cover

prostate specific antigen tests.

The House companion bill was amended by the Financial Institutions and Insurance Committee to specify that the Legislature would not be required to wait for the assessment. Assessments would be conducted by the commissioner of commerce with input from the commissioner of health.

The MMA supports the concept of a review of mandated benefits prior to legislative consideration.

INTRACTABLE PAIN BILL ADVANCES

The bill, S.F. 2227-Kiscaden, states that a physician who prescribes or administers a controlled substance to an individual diagnosed with a condition that causes intractable pain would not be subject to disciplinary action by the Board of Medical Practice. There are a number of exceptions. The measure would not apply if the patient was known to be using a controlled substance, or if the controlled substance was not approved by the Food and Drug Administration for pain relief. Nor could the controlled substance be administered to end the life of someone who was suffering intractable pain.

Neither the Minnesota Medical Association nor the Minnesota Board of Medical Practice has taken a position on this bill. The physician community is divided. Some believe that the bill would provide needed assurance for physicians that appropriate prescribing for intractable pain will not trigger a BMP investigation. Others fear the bill would encourage inappropriate prescribing.

Rural Health Recommendations Go to Health Department

The Rural Hospital Study Work Group of the Rural Health Advisory Committee (RHAC) has forwarded a number of recommendations to Anne Barry, commissioner of health. Among RHAC's recommendations are the following:

- Reduce duplicative regulations by developing a consolidated licensing system for health care facilities.

- Regarding the requirement that hospitals with attached nursing homes have directors of nursing, RHAC recommends legislative amendments that would allow small, rural hospitals to share directors of nursing.

- Educate hospital administrators and community pharmacists about the ability of registered nurses to dispense drugs in emergency situations.

- Require that all managed care contracts or policies include physician assistant services.

- Require that third-party payers not deny reimbursement of PA services based on stricter supervision standards than those in the state practice act.

- Request that DHS implement a standard billing practice that is more consistent with the billing practice of the federal Health Care Financing Administration.

RHAC plans to continue to study ways to preserve access to emergency medical care in conjunction with next year's study on alternative licensing for rural hospitals.

Commissioner Barry has responded to RHAC's recommendations in the following way:

- She supports the concept of a consolidated licensing system for health care facilities but will delay action until the alternative licensing study is completed.

- The MDH will include an amendment in its technical housekeeping bill that would give small, rural hospitals with attached nursing

homes the flexibility to share directors of nursing.

- The commissioner has asked her staff to contact the Board of Pharmacy and request that the board distribute the guidelines for after-hour emergency room dispensing by registered nurses. The guidelines will also be published in the Office of Rural Health and Primary Care newsletter.

- She rejected the recommendation that all managed care contracts or policies include PA services.

- DHS has recently adopted the standards of the new practice act as requirements for PA supervision and plans to disseminate information on that policy change.

- The commissioner has encouraged the DHS to implement a standard billing practice that is more consistent with that of HCFA and private payers.

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National Rural Health Conference Will Be Held in Minneapolis

The National Rural Health Association will hold its annual national conference May 15 to 18 at the Hyatt Regency in Minneapolis. Features include practical clinical sessions, discussion of policy issues affecting rural health services, personal and professional skill development for administrators and others in rural health, and presentations of recent rural health research results. For registration information, call the NRHA at 816/756-3140. • • • • •

MMA Doc Places in Dog Sled Race

Duluth physician and MMA member Larry A. Lemaster, M.D., finished an impressive second in the Beargrease 500 Mile Sled Dog Race from Duluth to Grand Portage and back in a five-day race, run January 21 to 26, 1996. Lemaster, a family practice physician at the Duluth Clinic, who has been mushing for 10 years, said it is a good way to relieve the stress caused by a busy practice. "Dog sledding is so different from the practice of medicine that it helps me relax. The race requires intense concentration and you're out in the woods away from the phones." Lemaster also found that the skills required of a physician came into play. "To race dogs, you have to be organized, persistent, and use strategy and common sense, just as you have to do in your practice."

MMA CEO Paul S. Sanders, M.D., in a letter of congratulations to Lemaster on his achievement, wrote, "Clearly this is a great challenge to mind, body and spirit, and you mastered it well. Our hats go off to you!" • • • • •

The Monitor

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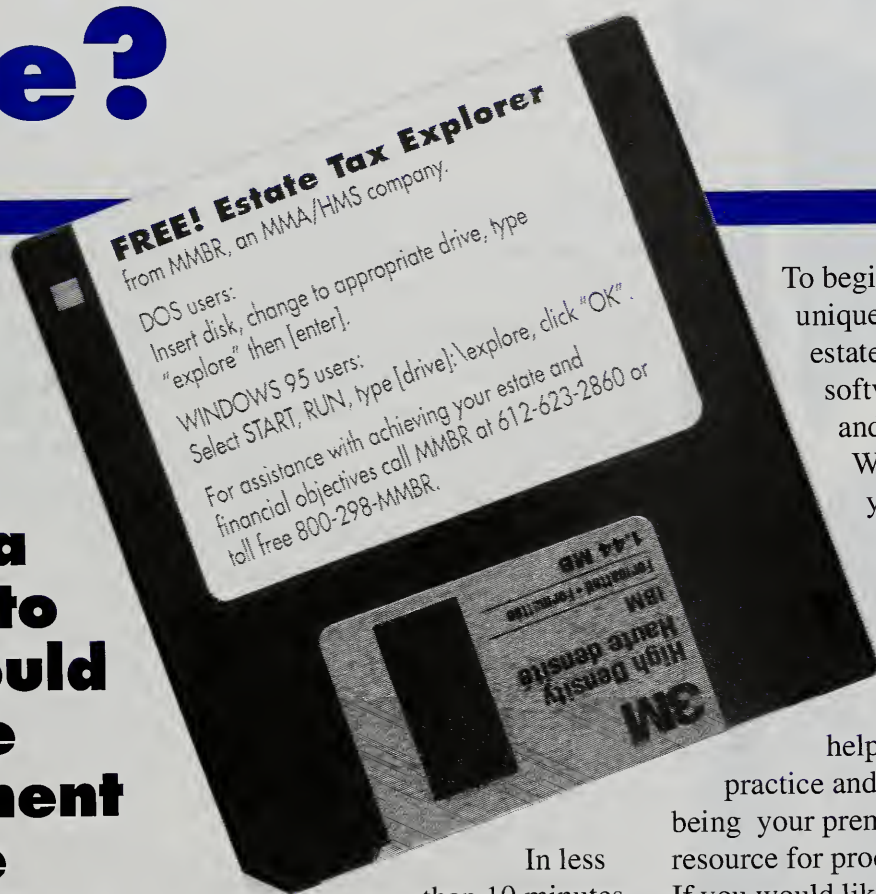
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The Sexual Assault Resource Service: A New Model of Care

This successful program, developed in Minnesota and expanding nationally, relies on sexual assault nurses to provide complete care to rape survivors and to collect crucial evidence.

Linda E. Ledray, R.N., Ph.D., F.A.A.N.

The Dallas evening news in November featured Minnesota's Sexual Assault Resource Service (SARS) as an exemplary program—one the Dallas community hoped would become a model for the area. SARS, developed at Hennepin County Medical Center, has been providing services to rape survivors in Hennepin County since 1977. Initially funded by the National Institute of Mental Health as a research demonstration treatment program, SARS originally provided only supportive counseling and crisis intervention to victims of sexual assault. As a result of research showing need, the program began providing complete evidentiary exams at the first community hospital in 1986.

The program, which has provided services to rape survivors at all Hennepin County hospitals since 1993, includes five essential elements: care of injuries, collection of evidence, evaluation and treatment of sexually transmitted diseases, evaluation and prevention of pregnancy risk, and crisis intervention and referral. The SARS program, expanding statewide and nationally, also plays an integral role in the conviction of rapists. In fact, a SARS nurse collected evidence that led to the arrest and conviction of a serial rapist in Minneapolis last year.

INITIAL CONCERNS

When SARS first began at Hennepin County Medical Center (HCMC), physicians expressed three primary concerns: that a nurse would miss injuries, that the evidentiary exam would not be as good as one completed by a physician, and that the physician would still be called to testify in court because a nurse would not be accepted as a credible witness.

These same physicians are now SARS' biggest advocates. Because SARS nurses work on call and are not otherwise on duty in the emergency department, they are able to spend whatever time is necessary to provide complete care. And physicians are now comfortable that injuries will not be missed. SARS nurses are trained to identify possible injuries, and a physician sees the patient first if injuries are apparent or suspected.

Physicians also have confidence in the nurses' ability

to conduct evidentiary exams and to testify in court. Because SARS nurses typically see a minimum of three rape survivors each month, and because they receive special training in conducting exams and in testifying, they are experts in caring for rape victims and are credible witnesses in court.

Emergency physicians and nurses have been so impressed with the program that it has been expanded to serve all hospitals in Hennepin County. Doctors and nurses who trained at Hennepin County Medical Center have requested that their hospitals implement SARS.

HOW THE SARS MODEL WORKS

Before the SARS program was developed, rape survivors in Hennepin County received the same care available at most hospitals. The emergency nurse on duty completed the bulk of the evidentiary exam, following the specifications of the Bureau of Criminal Apprehension (BCA) Sexual Assault Evidence Collection Kit. When the most senior physician on duty was available, he or she then performed a pelvic exam and collected vaginal, oral, and rectal specimens. The rape exams took an average of three and one-half hours of nursing time and 20 minutes of physician time.¹ Some cases took much longer. Both the physician and the nurse would be called to testify in court. Residents who completed the exams sometimes had left town by the time the case went to trial and had to be located to testify. In addition, busy ED physicians and nurses had difficulty accommodating last-minute court delays.

Today, SARS nurses work on call to all hospital emergency departments in Hennepin County. Whenever a sexual assault survivor comes into an ED, the on-call SARS nurse is paged. In the time it takes the SARS nurse to respond (no more than one hour), the ED staff evaluates and treats the rape survivor for injuries. SARS has found that only 27% of the individuals seen have even minor injuries, and only 3% have injuries requiring treatment. Fewer than 1% are hospitalized.² Unfortunately, those requiring hospitalization are often critically injured, and admission is usually to the ICU.

When the program began in 1977, SARS saw only adult female victims. Today, SARS treats men, women, and adolescents, although most victims are women.

All the SARS nurses are women. Studies showed that even male victims prefer to see a female nurse; they typically have been raped by a man and have generalized fear of and anger toward men.

Once the SARS nurse arrives, she is completely responsible for care of the rape survivor. If the survivor has not yet decided whether to report the rape, the SARS nurse will discuss the fears and concerns about reporting, knowing that the No. 1 reason most rape victims don't report is fear of the assailant. Three-quarters of all assailants tell their victims, "If you tell anyone, I'll come back and kill you ... rape you again ... rape your child." In SARS' 18 years of treating rape victims (more than 500 per year), only two assailants have acted on this threat. Except in domestic abuse cases, where retaliation is far more likely, these threats are a way for the assailant to maintain control of the victim after he has left.

In addition to helping the rape survivor decide whether she wants to report the rape and have an evidentiary exam, the SARS nurse provides five essential services: care of injuries; collection of evidence; evaluation and treatment of sexually transmitted diseases; evaluation and prevention of pregnancy risk; and crisis intervention and referral.

INJURIES

The SARS nurse evaluates the rape survivor for injuries and, when in doubt, asks the ED physician to consult. The SARS nurse does not do a complete physical exam, nor does the ED physician. That is not why the rape victim has come to the ED. This is emphasized to the survivor verbally and reiterated in the consent. Since routine medical care is not being provided, a Pap smear is not done as a part of the vaginal exam.

The SARS nurse never hesitates to ask the physician to see the survivor once again if she believes there may be an injury requiring further evaluation or treatment. Injuries are documented as evidence of force.

COLLECTION OF EVIDENCE

The SARS nurse completes the evidentiary exam using the BCA Sexual Assault Evidence Collection Kit, plus she collects additional samples depending on the specifics of the case.³ She looks for evidence that will help identify the assailant, provides proof of force or coercion, proves there was recent sexual contact, and corroborates the victim's story.

The single most frequent error that private practitioners and emergency department staff make when treating rape victims is not maintaining a proper chain of evidence. When that happens, the evidence collected cannot be used in court, and an identified suspect may be turned loose and not charged with the rape. SARS has worked with the police and the county attorney's office for years to determine what evidence is most useful in identifying a suspect and getting a conviction. These meetings have helped SARS improve its evidence collec-

tion procedure and have helped SARS nurses look for evidence beyond the requirements of the BCA Evidence Collection Kit.

A serial rapist in Minneapolis was identified in July 1995 because a SARS nurse knew to look beyond the usual specimens. This particular assailant, who always raped his victims both orally and vaginally, wore a condom and had the victim wash her mouth out so no identifying sperm could be recovered. When the assailant's last victim told the SARS nurse about her rape, it was apparent that she was a victim of the serial rapist. The nurse expected the usual oral and vaginal specimens to be negative, so she looked for other evidence. While looking for a skin specimen, the SARS nurse noticed a clump of the woman's head hair that apparently had been matted together by the assailant's semen. The victim agreed to let the SARS nurse cut the clump of hair for evidence. BCA analysis showed that the hair did contain sperm, and DNA analysis by the BCA matched a convicted sex offender, leading to his arrest.

It is not uncommon for a rape victim to be afraid to return to her home, so the SARS nurses ask for the phone numbers of any friends and relatives with whom the victim may decide to stay. The phone numbers help police locate the victim to obtain a statement when a suspect is identified. The victim must make a signed statement within 72 hours after a suspect is arrested, or the suspect is released.

SEXUALLY TRANSMITTED DISEASES AND PREGNANCY RISK

Most rape survivors fear contracting a sexually transmitted disease (STD), especially HIV. The SARS nurse evaluates the victim and informs her of her low risk for HIV. SARS tested 412 rape survivors at three and six months after a rape, and not one seroconverted. The risk is especially low if there was no rectal sex and no reason to believe the assailant was bisexual or an IV drug user. While it is not SARS policy to test for HIV in the ED, if victims are in a high-risk group, testing is recommended at three and six months after the assault. The risk for other STDs is higher. The SARS nurse offers the survivor prophylactic treatment for gonorrhea, syphilis, and chlamydia; reviews possible STD symptoms; and suggests when and where the victim can be further evaluated. She also evaluates the victim's risk of pregnancy and offers Ovral as a morning after pill.

CRISIS INTERVENTION AND REFERRAL

SARS nurses also arrange crisis intervention and supportive counseling and refer victims to community agencies. While many rape survivors want to go home and "forget about it," the SARS nurse knows this is not easy. Fear and anxiety resulting from the rape can significantly affect all aspects of the survivor's life—performance at work or school and interaction with family and friends.

A SARS nurse calls the rape survivor a day or two after the assault to see how she is doing medically, to evaluate the potential for secondary injury, and, when indicated, to get her into counseling. Since many victims

refuse to see a counselor, the SARS nurse will often recommend and provide the rape survivor with the self-help book "Recovering From Rape."⁴ This book is based on work done at SARS. The first half of each chapter focuses on helping the survivor recover; the other half is directed at helping her family and friends understand her response, and their own, to the rape.

SARS TRAINING

SARS specially trains sexual assault nurse clinicians. The training includes 22 components in a 46-hour CEU-approved course for all new employees, which results in program certification as a sexual assault nurse clinician. Training provides information related to the five essential elements of care discussed above. Also included is training in forensic medicine, such as maintaining proper chain of evidence, charting with a jury in mind, and testifying as an expert witness.

SARS was initially developed by clinical nurses. While many SARS nurses today have advanced degrees, it has been clearly demonstrated that an advanced nursing degree is not necessary to do the job successfully. A large pool of nurses with advanced degrees is not readily available in Minneapolis and would certainly not be available in rural communities. Other measures, such as using on-call nurses, have been adopted to significantly reduce program costs.

PROGRAM EXPANSION

The SARS program model is spreading rapidly throughout the country. In 1992, SARS hosted the first national meeting of sexual assault nurse clinicians/examiners in Minneapolis. Seventy-four nurses from more than 40 programs attended.

SARS has been so well received in Minnesota that state Attorney General Hubert H. Humphrey III recently recognized the program's value to sexual assault survivors and began efforts to develop a statewide network of programs. This is in line with SARS' long-term goals, which include the development of a model that can be exported to rural Minnesota.

MM

Linda Ledray is founder and director of the Sexual Assault Resource Service.

For more information about SARS, please contact: Linda E. Ledray, R.N., Ph.D., F.A.A.N, director, SARS, 525 Portland Avenue South, Minneapolis, MN 55415; 612/347-5832.

REFERENCES

1. Rambow B, Atkinson C, Frost TH, Peterson GF. Female sexual assault: medical and legal implications. *Ann Emerg Med* 1992;21:727-31.
2. Ledray LE. The sexual assault nurse clinician: a fifteen-year experience in Minneapolis. *J Emerg Nurs* 1992;18(3):217-22.
3. Ledray LE. The sexual assault examination: overview and lessons learned in one program. *J Emerg Nurs* 1992;18(3):223-32.
4. Ledray LE. *Recovering from rape*. 2nd ed. New York, NY: Henry Holt and Co., 1994.

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Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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Physician Recruitment by Tax-Exempt Organizations

The IRS has issued proposed guidelines on physician recruitment incentives that don't endanger a hospital's tax-exempt status.

Margo S. Struthers, J.D., and Billie Zippel, J.D.

Physician recruitment is a highly charged topic for both physicians and hospitals. Federal tax laws frequently put physicians and hospitals at odds because certain compensation arrangements and physician incentives can jeopardize a hospital's tax-exempt status. The Internal Revenue Service has traditionally prohibited a physician from financially benefiting more than "incidentally" in relation to the benefit provided to the hospital and community from the physician's services. Recruitment incentives also are affected by laws prohibiting physician self-referrals and remuneration for referrals.

Until recently, there was no general guidance from the IRS on which physician recruitment incentives would threaten a hospital's exempt status. Guidance was on a case-by-case basis. In March 1995, the IRS issued a proposed revenue ruling, describing four situations in which physician recruiting packages would not jeopardize the hospital's tax-exempt status and one situation in which the hospital would lose its exempt status.¹

TAX-EXEMPTION LAWS

A basic knowledge of the public benefit requirements for tax-exempt status is important to understanding the issues. Organizations that are exempt from income tax under Internal Revenue Code section 501(c)(3) must be organized and operated for a charitable, scientific, public safety

testing, literary, or educational purpose. Promotion of health has long been recognized as a charitable purpose.

The hospital also must continually satisfy two operational tests to retain its tax-exempt status. When seeking to recruit physicians, tax-exempt hospitals must observe the following two rules: 1) the prohibition against private inurement, and 2) the requirement that the organization be operated for a public, not a private, benefit. Private inurement occurs only when the individual is an insider, e.g., a hospital board member, employee, or, arguably, even a physician with only medical staff privileges. In most cases, a physician being recruited is not yet an insider, so private inurement generally is not an issue in physician recruitment. However, the second requirement, known as the private benefit test, must be considered. A tax-exempt hospital must operate for a public purpose and, therefore, not benefit private interests more than "incidentally."

The private benefit test is satisfied if the benefit to a private individual is qualitatively and quantitatively incidental compared with the overall public benefit achieved in the transaction. A private benefit is *qualitatively* incidental if a public benefit cannot be achieved without providing the private benefit. It is *quantitatively* incidental if it is insubstantial compared with the public benefit.

Accordingly, a tax-exempt hospital must determine 1) whether the

public would or could have received the recruited physician's services without providing some financial benefit to the physician and 2) whether the private benefit (financial incentive) is insubstantial compared with the public benefit resulting from the physician's services. This test applies to physicians employed by the hospital, as well as physicians who are independent contractors or who have only medical staff privileges.

Despite restrictions on financial incentives, a tax-exempt hospital may pay reasonable compensation for services rendered to, or benefits conferred upon, the hospital. Determining whether compensation is reasonable involves careful analysis of the arrangement. Generally, the determination is based on a review of the duties and responsibilities of the individual in question, as well as the compensation received by others with similar responsibilities and holding comparable positions at similar organizations.

THE PROPOSED RULING

The proposed ruling is unique. The IRS does not usually propose revenue rulings and give opportunity for comment. The IRS received more than 20 comments, primarily from health care associations, demonstrating the importance of the issue to the health care community. While the guidance provided in the proposed ruling (and the final ruling when it is published) is important, and follow-

ing the guidance is good tax planning, a ruling is not law; it is only the IRS' view of the law. The final ruling is expected to be out in the first half of 1996.

The proposed ruling addresses 1) recruitment of a physician who relocates to the hospital's geographic area; 2) recruitment of a physician who already practices in the hospital's community but is not on the hospital's medical staff; and 3) recruitment of a physician already serving on the hospital's medical staff but not currently providing needed Medicare or charity care services.

The proposed ruling does not define the extent of permissible physician recruitment incentives. Instead, the situations described are merely examples that the IRS identifies as meeting the private benefit tests. All five situations have different facts. The most notable common factor is that the hospital must document its determination of community need, typically found in a shortage of care in the community, or at least at that particular hospital. This may be a shortage of physicians in general, a shortage of specialists, or a shortage of physicians willing to provide Medicare or charity care services.

Other important requirements are that 1) the incentive agreements are properly documented; 2) the incentives are reasonable and utilize commercially reasonable terms; 3) the incentives are approved by the hospital board of directors; and 4) the offer of incentives to the physician is reasonably related to the accomplishment of the hospital's charitable purposes.

The proposed ruling modifies past interpretations of the private benefit rules. The qualitatively incidental test is unchanged; the hospital is still required to show that it must provide the benefit to the physician to obtain the physician's services. However, the quantitatively incidental benefit rule has undergone a proposed transformation. The traditional rule permitted no more than an insubstantial private benefit.² The proposed ruling, however, discusses the rule in terms of the public benefit outweighing the private benefit, which may

give hospitals more flexibility in providing incentives.

SUSPECT INCENTIVES

Following is a summary of some incentives the IRS identified in the past as suspect or problematic. As noted below, some of these incentives now are described as acceptable in the

“Perhaps the biggest reversal the IRS made in the proposed ruling is the approval of signing bonuses.”

proposed ruling if the incentives are commercially reasonable, well-documented, approved by the hospital board, and reasonably related to the hospital's exempt purpose.

LOANS, LINES OF CREDIT, AND LOAN GUARANTEES

Providing loans to physicians on terms that are more favorable than those available commercially may result in excess private benefit or private inurement.³ For example, nominal interest or no interest at all provides a benefit to physicians that is obtained only by virtue of their relationship to the hospital. The language of the proposed ruling indicates that such loans may be possible if the community need for the physician is great and the loan terms are commercially reasonable. The proposed ruling uses the term commercially reasonable throughout its descriptions of the different transactions. While it is difficult to specifically define commercially reasonable, an excellent way to defend a practice is to obtain surveys of industry practices that show the incentive is a common practice and, therefore, reasonable.

LOAN FORGIVENESS

Some hospitals forgive principal and/or interest owed by a physician if the physician remains an employee or a

member of the medical staff for a fixed period of time. The IRS has yet to concede that such a practice meets the private benefit test: loan forgiveness is not among the practices specifically approved in the proposed ruling. This does not mean, however, that the practice is prohibited. At a meeting last summer with attorneys representing tax-exempt health care organizations, two IRS representatives discussed how difficult it is to provide examples of acceptable incentives.⁴ The IRS representatives did not say the IRS disapproves of this incentive; they merely agreed that this is an issue.

INCOME GUARANTEES

Income guarantees generally have been prohibited unless the guarantee was treated like a loan, and the physician was required to repay to the hospital the difference between what he or she earned and the total guaranteed income at a later date. The proposed ruling arguably diverges from earlier rulings by allowing income guarantees under certain circumstances without making any reference to repayment. The proposed ruling describes guarantees that are for no more than three years and that are for total income within the range of compensation for similar physicians in that geographic area. Given prior adverse rulings, it is imperative that a hospital be able to defend the amount of income guaranteed and the time period of the guarantee as commercially reasonable.

OFFICE/EQUIPMENT SUBSIDIES

The IRS generally has viewed the renting of office space or equipment to physicians at below-market rates as *not* meeting the qualitatively incidental test. In the past, the IRS did not accept the argument that the private benefit to the physician was necessary to obtain the physician's services. The proposed ruling appears to depart from the traditional line of thinking, since it approves below-market rent for a limited period of time if the discount and terms are commercially reasonable, without reference to the hospital's need to offer such incentives to obtain the services.

INTERVIEW, TRAVEL, MOVING, AND RELOCATION EXPENSES

Reimbursing a physician for relocating to the community, as long as it is within the general IRS guidelines for employee reimbursement and moving expense deductibility, is acceptable under the proposed ruling. This is true even if the physician is not an employee of the hospital. Nevertheless, reimbursement of interview, travel, and relocation expenses must be reasonable.

CONTINUING MEDICAL EDUCATION EXPENSES

Traditionally, this has not been a problem when the physician is an employee of the hospital. However, subsidizing the physician's expenses, including travel expenses, may in certain cases cause problems even when the physician is an employee—for example, if the travel is extravagant.⁵ The amount subsidized must be reasonable. Furthermore, the Internal Revenue Service will likely scrutinize, if not prohibit, arrangements involving a hospital's payment of travel expenses for a physician's spouse.

PRIVATE PRACTICE START-UP SUBSIDY/SUPPORT

In the past, the IRS has generally prohibited providing physicians with employees, administrative support, or other similar aid.⁶ The proposed ruling indicates that such subsidies may be allowed if the agreements are limited in time.

MALPRACTICE INSURANCE

Subject to reasonable compensation limits, hospital payments for employees' malpractice insurance are generally acceptable without limitation. In addition, the proposed ruling indicates that such payments are acceptable if they are made on behalf of a medical staff member who is not an employee but who agrees to treat Medicare/Medicaid and charity care patients. The proposed ruling approves of a one-year agreement to make such payments.

TAIL INSURANCE

The proposed ruling approves of a hospital paying the tail insurance for

a physician who will be relocating to the hospital's geographic area.

SIGNING BONUS

Perhaps the biggest reversal the IRS made in the proposed ruling is the

approval of signing bonuses. The proposed ruling approves a \$5,000 bonus paid to a physician finishing residency who agrees to move to a rural area described as a Health Professional Shortage Area.

continued

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MEDICAL DIRECTOR APPOINTMENT

Paying a physician to provide services as a medical director should be valid as long as the payments are reasonable in terms of the services provided within the community.⁵ The services must be needed and actually provided. The proposed ruling does not address this particular practice.

PERSONAL FINANCIAL ASSISTANCE

The proposed ruling states that guaranteeing the mortgage on a primary care physician's house in a federal Health Professional Shortage Area is acceptable. However, common sense suggests that providing such assistance will only be approved if the physician is moving from another community.

FRAUD AND ABUSE AND STARK II LAWS

The last hypothetical example in the proposed ruling describes a hospital found to have knowingly and willfully violated the Medicare and Medicaid anti-kickback statute (fraud and

abuse laws). The proposed ruling states that the hospital is not in compliance with tax-exemption laws since it is not operated for charitable purposes because of its engagement in substantial unlawful activities. Therefore, a discussion of physician recruitment practices would not be complete without at least mentioning the fraud and abuse laws, as well as federal self-referral prohibition laws (Stark II).

Under the fraud and abuse laws, it is illegal to knowingly and willfully offer or receive remuneration in return for or as inducement for referring business reimbursed under the Medicare or Medicaid programs. The U.S. Department of Health and Human Services has issued several safe harbors, including a proposed safe harbor regarding physician recruitment, that set forth certain arrangements that will not be subject to prosecution under the fraud and abuse laws if such arrangements meet all of the criteria outlined in the safe harbor.

Generally, under the proposed

physician recruitment safe harbor, rural hospitals could offer recruitment incentives to induce a physician (1) who has been practicing within his or her current specialty for less than one year and who is in the hospital's geographic area to establish staff privileges at the hospital; or 2) to relocate his or her primary place of practice to the geographic area served by the hospital.

The Stark II laws prohibit physicians from referring Medicare or Medicaid patients for designated health services to an entity in which the physician (or an immediate family member) has a financial relationship. Such designated health services include clinical laboratory services; physical and occupational therapy services; radiology and other diagnostic services; durable medical equipment; parenteral and enteral equipment and supplies; prosthetics, orthotics, and prosthetic devices; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. A financial relationship includes almost any



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ownership or investment interest and many compensation relationships between the referring physician and the entity providing the designated health services.

Like the fraud and abuse physician recruitment safe harbor, Stark II provides for an exception to the general rule against self-referrals for certain physician recruitment activities. Under this exception, a hospital may provide recruiting incentives to a physician if: 1) the incentive is offered to induce the physician to relocate to the geographic area served by the hospital; 2) the physician is not required to refer patients to the hospital; and 3) the amount of remuneration under the arrangement is not influenced (directly or indirectly) by the volume or value of referrals by the referring physician.

Generally, with respect to permitted physician recruitment activities, the fraud and abuse physician recruitment safe harbor and the Stark I exception are more restrictive than the relevant tax-exemption laws and, in particular, the relatively expansive

proposed ruling. The fraud and abuse and Stark II laws apply to all participants in the health care industry, not just tax-exempt entities. Nevertheless, for tax-exempt health care entities, the challenge will be to use recruiting incentives that comply with the tax-exemption laws, as well as the applicable fraud and abuse and Stark II laws.

CONCLUSION

The proposed ruling cannot answer all the questions about allowable physician recruitment incentives or cover every possible scenario; however, two guiding principles emerge. First, there must be sufficient community need to justify paying an incentive. Second, the total value of the incentive package must be reasonable, and the terms of the individual incentives must be commercially reasonable. Reasonableness and commercial reasonableness depend on the physician, the market, and the magnitude of the need. While these principles do not give hospitals or physicians answers to all compensa-

tion questions, they do provide some guidance in determining a compensation package. **MM**

Margo Struthers is a partner and Billie Zippel is a senior associate with Oppenheimer Wolff & Donnelly in Minneapolis.

REFERENCES

1. Ann. 95-25, 1995-14 I.R.B. 10.
2. Gen'l Couns. Mem. 37789.
3. 1992 Hospital Audit Guidelines § 333.3(10), Gen'l Couns. Mem. 37789; Lowry Hospital v. Commissioner, 66 T.C. 80 (1976).
4. Edited Transcript of the August 4, 1995, Breakfast Session of the Subcommittee on Health Care Organizations of the ABA EO Committee. The Exempt Organization Tax Review, Vol. 12, No. 5, November 1995.
5. Hermann Hospital Closing Agreement. Highlights and Documents. Oct. 17, 1994, at p. 648.
6. Hermann Hospital, 1992 Hospital Audit Guidelines § 333.3(7)(c); Harding Hosp. v. Commissioner, 505 F.2d 1068 (1974); Gen'l Couns. Mem. 39598.

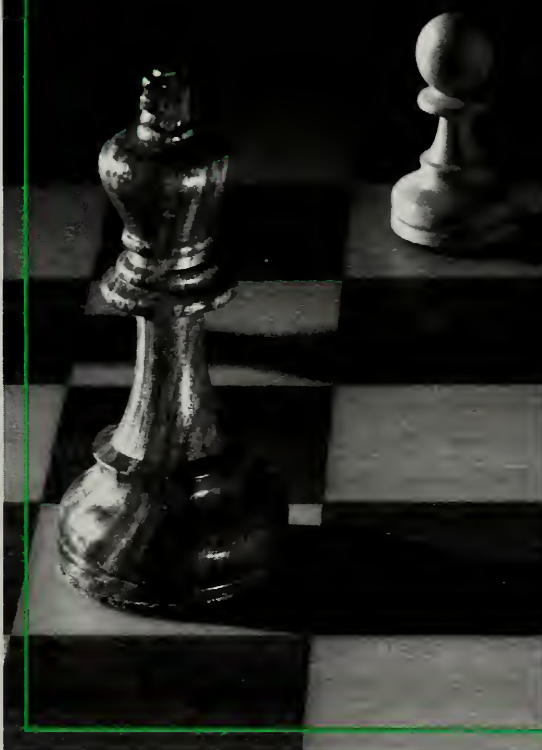
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Peer Review

Federal and State Protection

*Congress and the Minnesota Legislature
have encouraged professional peer review by
exempting it from antitrust and other liability.*

Katherine E. Kennedy, J.D.

Professional peer review, used to examine the quality of care delivered by staff physicians and others who have applied for privileges, has for years been recognized as a principal mechanism to improve medical care. State licensure and accreditation standards require it. But successful lawsuits threatened its viability until state and federal governments passed laws protecting peer review from antitrust and other liability.

FEDERAL HEALTH CARE QUALITY IMPROVEMENT ACT

In the past, several physicians who lost medical staff privileges or membership following review filed lawsuits against hospitals and medical staffs alleging antitrust violations. The threat of treble damages made antitrust litigation particularly burdensome for defendant hospitals and physicians. In one famous case, *Patrick v. Burgett*, the U.S. Supreme Court reinstated a multimillion-dollar antitrust damage award to a plaintiff physician who sued his former partners.

In response to the award of antitrust damages in *Patrick*, Congress passed the Health Care Quality Improvement Act of 1986. The act reflects Congress' concern that without legal protection, physicians would not participate in effective peer review activities. Congress intended to encourage peer review by establishing immunity from antitrust liability

and certain other federal and state claims. The protection extends to defined "peer review bodies," their members and staff, individuals under contract or other agreement with the peer review body, and any individuals who participate with or assist them.

The protection provided is not absolute. The act confers immunity from liability for damages in certain claims, not immunity from suit. Additionally, the protection does not apply to actions brought under civil rights laws, actions seeking injunctive or declaratory relief, or actions by state or federal governments, such as action brought by the Justice Department or state attorneys general.

Further, the limited protection applies only to peer review actions conducted in good faith, defined as action that meets the act's reasonableness and procedural requirements. Specifically, the act requires that action be taken in *reasonable belief* that it will improve the quality of health care following a *reasonable effort* to obtain the facts and in the *reasonable belief* that the action was warranted. The act presumes that professional review action meets these standards, unless the physician challenging the action can prove that it more likely than not was unreasonable.

The act specifies that professional review action must relate to the physician's competence or professional conduct. Limited protection from liability does not apply to profession-

al review action that is based on a physician's association with a professional society or that is taken for business and economic reasons.

Judicial interpretation of these requirements is contained in a developing body of case law. The courts also have addressed the procedural standards outlined in the act. The act requires that professional review action be taken only after adequate notice and hearing to the physician under review. Although specific, the notice and hearing standards are not mandatory. Rather, compliance with the standards provides a safe harbor from liability in antitrust and other claims. Failure to meet the standards does not subject reviewers to liability; instead, it requires them to prove that the action was fair.

MINNESOTA PEER REVIEW PROTECTION

Minnesota state law provides similar liability protection to review organizations that fit the statute's structural requirements and that fulfill its purposes. Although it lacks the specific procedural provisions of the federal Health Care Quality Improvement Act, the Minnesota statute—called Health Care Information and Review Organizations—does establish a reasonableness requirement. Minnesota law provides that no review organization or members of a review organization shall be held liable for damages or other relief for action taken in the reasonable belief

that action was warranted after a reasonable effort to ascertain facts. An exception exists if the review organization, its members, directors, officers, counsel, or staff took action motivated by malice.

In addition to providing liability protection, the statute requires confidentiality. The statute states that "[all] data and information acquired by a review organization, in exercise of its duties and functions, shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of

the purposes of the review organization and shall not be subject to subpoena or discovery."

The statute further provides that records and proceedings of review organizations shall not be subject to discovery or introduction into evidence in any civil matter involving the physician and the issue being reviewed. This provision does not prevent a party from attempting to obtain the review information. Instead, the provision is a defense to be used against any effort to reach the information. Even if the information

were obtained, it could not be used at trial.

The statute includes two exceptions that allow parties access to confidential information. If the information used in the review is otherwise available from original sources, then it is not immune from discovery or use in trial. For example, medical records evaluated in a review can be obtained through request or subpoena since they were otherwise available. This exception prevents abuse of the review process to shield information that would otherwise be avail-

The Minnesota Medical Association's Peer Review Program

The Minnesota Medical Association introduced in 1994 a formal Peer Review Program to assist physicians, their patients, as well as health care organizations. The external program offers qualified, impartial consultants to hospitals, clinics, and other health care organizations that need assistance with the investigative phase of peer review. The internal program reviews complaints that patients or others submit about member physicians. The goal of both programs is to improve the quality of health care delivered in Minnesota.

External Program

Following are the key benefits of the MMA's external program—MMA Peer Review Consultation Services.

Provides quality peer review

- Consultants are credentialed for ability.
- Consultants receive mandatory training.
- Organizations receive a standardized consultant report.
- The report is reviewed and approved by:
 - MMA physician oversight committee;
 - physician consultant; and
 - MMA legal staff.

Improves quality of care

- The review:
 - is credible, impartial;
 - is comprehensive, based on information from varied sources;
 - is educational; and
 - enhances informed decision-making by medical staff leadership.

Identifies areas for improvement

- The review helps improve the physician's clinical practice.
- The review helps organizations make system-wide improvements, i.e., in quality assessment process.

Enhances legal protection

- The program is structured to achieve maximum legal protection.
- The MMA indemnifies consultants.

Internal Program

Following are the key benefits of the internal review program—MMA Professional Performance Review.

Improves quality of care

- The program:
 - provides confidential, educational review;
 - assists county medical societies with complaint review; and
 - provides an alternative to Board of Medical Practice review.

Improves credibility of profession

- The program:
 - provides patients with a resource for complaint review; and
 - imposes discipline of member physicians when required.

For more information about the MMA's Peer Review Program, contact the MMA Legal Department, 612/378-1875 or 800/999-1875.

able outside of the review process.

The second exception allows physicians challenging reviews to obtain and use as evidence confidential review information. Without access to such information, physicians would be unable to challenge review actions that affect their staff membership or privileges.

NATIONAL PRACTITIONER DATA BANK

The remaining section of the Health Care Quality Improvement Act is important because it establishes the National Practitioner Data Bank, a national repository of data about physicians and other health care practitioners.

REPORTS REQUIRED

The act requires certain defined health care entities, such as hospitals, professional societies, and licensing agencies, to report disciplinary action

taken against a practitioner's privileges, membership, or license. The entity must report to the state licensing board, which in turn must report to the Data Bank. Additionally, professional liability insurers must report payments made on behalf of a physician or other practitioners.

Thus, the Data Bank collects information on adverse actions related to professional competence taken against a practitioner's clinical privileges, professional society membership, or license. In turn, the Data Bank releases the information to health care organizations and licensing boards that investigate a practitioner's qualifications for clinical privileges or licensure. Thus, the information is available in the credentialing process.

QUERIES REQUIRED

To ensure that the information is used in credentialing, the act requires

hospitals to query the Data Bank when a practitioner applies for medical staff membership or clinical privileges and biennially thereafter. Failure to query can lead to legal penalties, including loss of liability protection available under the act.

Typically, medical malpractice insurers and attorneys may *not* query the Data Bank. However, if a hospital failed to query about a particular practitioner, a medical malpractice plaintiff or the plaintiff's attorney may access the information. To do so, the plaintiff must have filed a complaint in court and must submit evidence to the U.S. Department of Health and Human Services, which operates the Data Bank, that the hospital failed to query as required. Any information then released may be used in the suit against the hospital only, and not against the practitioner.

With that limited exception, Data Bank information is confidential and available to only a few defined entities. Improper disclosure or use of the information could result in significant civil fines.

After five years in operation, the Data Bank still generates controversy. Current discussion focuses on whether Data Bank information should be available to the public. Another issue is whether this costly repository of data actually improves the quality of medical care through its system of flagging potentially incompetent practitioners.

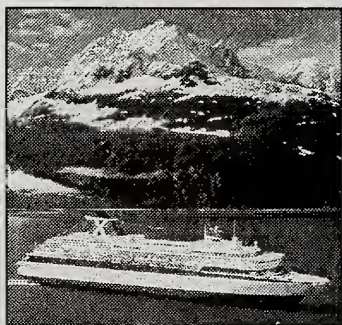
CONCLUSION

Overall, the federal Health Care Quality Improvement Act and Minnesota law provide a framework in which physicians can conduct effective peer review with limited exposure to liability for antitrust and other claims. Concomitantly, these laws protect reviewed physicians from a corrupted peer review process. **MM**

At the time she wrote this article, Katherine Kennedy was an attorney and director for the MMA Peer Review Program. Currently, she is practicing law with Jardine, Logan & O'Brien in St. Paul.

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People and Places Making Medical News

People

HealthEast Medical Director

HealthEast has appointed **Stephen J. Kolar, M.D., F.A.C.P.**, medical director for systems integration, a new position. In the role, Kolar will lead development of integrated systems for HealthEast services, clinics, and the communities served by HealthEast, providing a clinical link as HealthEast moves from a hospital-based system to a community-centered care organization. Kolar, an internist, has held numerous leadership positions on health care boards and committees.

East Metropolitan Health Organization CEO

East Metropolitan Health Organization has appointed **Brian F. McInerney, M.P.H., J.D.**, chief executive officer. Previously, he was in senior management at United HealthCare. East Metropolitan Health Organization is a shareholder corporation representing about 150 specialty physicians.

HealthPartners Additions

Macaran (Mac) Baird, M.D., M.S., has joined HealthPartners as associate medical director for primary care, responsible for coordinating the primary care services delivered through 19 HealthPartners-owned primary care clinics in the Twin Cities. Before joining HealthPartners, Baird served for eight years as chair of the Department of Family Medicine at State University of New York Health Science Center in Syracuse, New York. He trained and practiced in Minnesota before moving to academic medicine.

Jill Sammon Larson has joined HealthPartners as director of

government relations. She is responsible for implementing HealthPartners' public policy positions, including legislative lobbying and state regulatory relations. Previously, she was vice president of public policy at the Metropolitan Healthcare Council, and prior to that she was legislative relations director for Gov. Arne Carlson.

Ron Anderson has joined HealthPartners as vice president of HealthPartners Ventures, responsible for new market development of HealthPartners' products and management services. He joins HealthPartners from the Mayo Clinic in Scottsdale, Arizona, where he served as chair of the Division of Managed Care. Before that, he was with the Mayo Clinic in Rochester.

Children's Health Care-St. Paul Appoints Chief of Staff

Christopher L. Moertel, M.D., has been appointed chief of staff for Children's Health Care-St. Paul for 1996. Moertel is medical director of hematology/oncology at Children's-St. Paul and a clinical assistant professor of pediatrics at the University of Minnesota.

Places

Mayo Opens Children's Hospital

Mayo Clinic has opened the new 85-bed Mayo Eugenio Litta Children's Hospital within Saint Marys Hospital in Rochester. The hospital includes a neonatal intensive care unit, a pediatric intensive care unit, an infant/toddler general care area, and areas for preschool and school-age children and adolescents. It also includes patient rooms large enough for parents to stay with their children.

The hospital was funded

almost entirely by private gifts. It is named in honor of Eugenio Litta, a son of one of the hospital's benefactors.

Cannon Valley Clinic Planning New Site

Cannon Valley Clinic—part of Mayo Health System—is planning to build a new clinic on the District One Hospital campus in Faribault. The hospital's board has approved the clinic's proposal, which includes leasing 53,700 square feet from the hospital and constructing a 13,000-square-foot building adjacent to the hospital. The clinic would be attached to the hospital by an above-ground walkway.

As part of the agreement, Cannon Valley Clinic would sign a 90-year lease and would pay fair market value for the land on which the clinic would sit, along with property designated for clinic parking and one-half the cost of the walkway.

HealthPartners Planning Woodbury Clinic

HealthPartners has begun construction of a new clinic and regional urgent care center in Woodbury, one of the fastest-growing cities in Minnesota. The medical center, which will be located on the Tamarack Business Campus at Radio Drive and Seasons Parkway just south of Interstate 94, is scheduled to open in August.

The new site will be available to patients from the entire community—including those who belong to other health plans—and will include non-HealthPartners physicians on staff. It will be the new site for Woodbury's oldest family practice, Woodbury Family Medical Center, P.A.

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health care, including primary care for all ages, ob/gyn, eye exams and optical services, pharmacy, laboratory, radiology services, and urgent care. The facility initially will be staffed by nine physicians and other health care providers.

Southwest Internists Renamed

Diamond Lake Medical Clinic is the new name of Southwest Internists, located at 5346 Lyndale Avenue South in Minneapolis. The clinic chose a new name to reflect the group's growth as a multi-specialty clinic, as well as its long-standing presence in the Diamond Lake neighborhood. The clinic's address and telephone number remain the same.

Cloquet Hospital Offers Free Day for New Moms

Cloquet Community Hospital is allowing new mothers to stay in the hospital one extra day at no charge if their insurance coverage won't pay for a stay of more than

24 hours. Concerned by insurers increasingly restricting hospital stays for new mothers to 24 hours, the hospital's administrator and medical staff began offering the free room and board—usually a \$309 charge—on February 1. Care related to additional procedures on the second day is charged to the patient or her insurer. About 120 babies are born at the hospital each year, and hospital administrator Jim Carroll predicted that 10 to 15 mothers a year might take advantage of the offer.

The Minnesota Legislature is considering a bill that would require insurers to cover 48 hours of hospital care for women with uncomplicated vaginal deliveries. In the meantime, Cloquet's hospital is continuing its offer.

Socioeconomics

Wisconsin's Myrtle Werth Joins Mayo

Myrtle Werth Medical Center in Menomonie, Wisconsin, has approved a proposal to become part of the Mayo Health System effective March 1. The medical center will be named Myrtle Werth Hospital—Mayo Health System. Together, Myrtle Werth, Red Cedar Clinic (also part of the Mayo Health System), and Mayo will jointly develop a closely aligned health care delivery system that will provide care to patients in Menomonie and the surrounding area. The groups plan to bring new primary care physicians to the area to meet a growing demand for services.

United HealthCare Buying Nashville's HealthWise

Minnetonka-based United HealthCare is purchasing Nashville-based HealthWise, subject to regulatory and shareholder approvals, in a stock transaction valued at about \$289 million. HealthWise has 154,000 members in its health maintenance organizations, which are located in Maryland, Kentucky, Tennessee, and Arkansas. The

company also was expanding into Washington, D.C. United plans to combine HealthWise with its existing operations in the region. Its health plans and specialty care services already serve 680,000 members.

The agreement calls for United to issue 4.6 million common shares in exchange for all outstanding equity ownership and stock options in HealthWise. The deal would provide 0.6475 of a United share for each HealthWise share.

Minnesota Internal Medicine Joins HealthEast

Minnesota Internal Medicine, with two clinics in St. Paul, has joined HealthEast. The clinics' staffs include eight internal medicine physicians, one rheumatologist, and a nurse practitioner.

Ob/Gyn Clinics Merging

Fairview Riverside Obstetrics and Gynecology Associates and Professional Obstetrics and Gynecology have merged to become Fairview Riverside Ob/Gyn & Nurse Midwifery. The merger brings together five obstetric and gynecology physicians and a team of six certified nurse midwives to provide comprehensive obstetric and gynecology services, including amniocentesis, ultrasound evaluation, cesarean section, colposcopy, and treatments of incontinence and infertility. The physicians are on staff at Fairview Riverside Medical Center.

Physician Pay Drops in '94

The American Medical Association recorded the first ever drop in physician income in 1994. Median income for nonfederal physicians fell from \$156,000 in 1993 to \$150,000 in 1994, a 3.8 percent drop. Residents were not included in the survey, conducted by the AMA's Center for Health Policy Research.

The drop affected 14 of the 21 specialties tracked. Pay remained steady for six specialties. Only one,

orthopedic surgery, reported an increase—a moderate 0.7 percent. The largest decreases were for cardiovascular disease specialists (down 12 percent to \$220,000); otolaryngologists (down 11.1 percent to \$225,000); and pathologists (down 10.6 percent to \$152,000). A quarter of all physicians made less than \$105,000, while another quarter made more than \$220,000.

Minnesota HMOs Faring Well

Minnesota's 12 health maintenance organizations are in good health, according to a new Health Department report, "1994 HMO Operations in Minnesota." In addition, Minnesota has the strongest, most comprehensive HMO consumer protection laws in the nation, according to a national study by the Los Angeles-based Center for Health Care Rights.

"Minnesotans are truly leading the rest of the country," said Minnesota Health Commissioner Anne Barry. "It is reaffirming to know that our relationship with HMOs has helped shape an outstanding health care system."

The Health Department's report shows that about 1.167 million Minnesotans were enrolled in HMOs in 1994, a small decrease from about 1.174 million in 1993. The decrease likely occurred because more employers are becoming self-insured, assuming financial risk for employee benefit plans.

The report, which summarizes information on enrollment, finances, health care utilization, complaints, and performance measures, shows that all Minnesota HMOs meet the state's minimum requirement for financial reserves.

More Employers Offering Managed Health Care

More Minnesota employers are offering managed care health plans, and larger numbers of employees are choosing such plans, according to a survey by the benefits analysis division of Deloitte & Touche. The survey found that 157 of 177

businesses that responded offered a managed care plan in 1995, compared with 142 the year before. Most companies were small, with fewer than 1,000 employees.

Enrollment in HMOs, PPOs,

and point-of-service plans increased, while enrollment decreased for indemnity plans. Most surveyed companies offered employees a choice of two or more plans; this was especially true for larger employers. *continued*

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Managed Care Lowers Costs and Mortality Rates

Hospitals in cities with high levels of managed care, including the Twin Cities, Rochester, and St. Cloud, report significantly lowered costs, reduced length of stay, and decreased mortality rates, according to a KPMG Peat Marwick study of 11.7 million patients at 3,700 U.S. acute care hospitals.

Length of hospital stays in the Twin Cities is 19 percent shorter than the national average, according to the company's study, "The Impact of Managed Care on U.S. Markets." Costs were 3.6 percent lower. In Rochester, hospital stays were 13 percent below the national average and costs 3 percent lower. Hospital stays in St. Cloud were even lower than in the Twin Cities, at 23 percent below the national average. St. Cloud costs were 4.7 percent below average.

Overall, hospital costs in high managed care markets were approximately 11 percent below the national average and 19 percent below hospital costs in low managed care markets. The study also found that managed care has not resulted in higher mortality rates or complication rates. In fact, the risk-adjusted mortality rates in high managed care markets were 5.25 percent below the national average.

HMO Costs Down

The average cost to U.S. employers using health maintenance organizations fell 3.8 percent last year, from \$3,385 per worker to \$3,255, according to a survey of about 2,800 companies by the benefits consulting firm Foster Higgins. HMO enrollment jumped from 23 percent of workers in 1994 to 27 percent last year.

Overall health benefits spending by U.S. employers increased 2.1 percent to an average of \$3,821 per employee. The increase was

significantly higher in the Twin Cities—7.2 percent to an average of \$4,267 per employee. The increase for Minnesota was about 8.1 percent to an average of \$4,090 per employee.

Medical Facility Inspectors Laid Off

In an effort to offset rising costs and decreasing federal funding, the Minnesota Department of Health has laid off 15 of the department's 100 staff who inspect medical care facilities. To reduce workload, the Health Department plans to act on fewer complaints; conduct fewer inspections of such facilities as hospitals, surgery centers, and renal dialysis centers; and extend the waiting time for small medical-service businesses seeking approval to serve Medicare clients.

Linda Sutherland, who heads inspections for the Health Department, said funding for the inspection program has dropped while salaries and overhead costs have increased. In January, Congress approved funding for state inspections at \$20 million less than what the U.S. Department of Health and Human Services sought. Minnesota will lose about \$300,000 in funding. The Health Department had already eliminated administrative and clerical positions but decided it also had to eliminate inspector positions.

Rates, Trends, Data

One-Day Maternity Stays Increasing

One-day maternity stays for uncomplicated vaginal deliveries in the Twin Cities metropolitan area increased nearly sevenfold between 1985 and 1995, according to a Minnesota Hospital and Health-care Partnership study. The study, which looked at hospital discharge patterns, found that 42.5 percent of women who had uncomplicated vaginal deliveries were discharged after one day, compared with 6.2 percent in 1985.

In the late 1980s, two-day stays for an uncomplicated vaginal delivery increased as three-day stays declined. In the early 1990s, two- and three-day stays both dropped as one-day stays skyrocketed.

A similar pattern emerged for uncomplicated cesarean deliveries. Three-day stays for the procedure increased from 6.6 percent in 1985 to 64.7 percent in the first quarter of 1995. The percent of four-day stays decreased since 1990 from 62.5 percent to 22.0 percent in the first quarter of 1995. Five-day stays dropped from 29.7 percent in 1985 to 4.9 percent in 1995.

The study found a link between length of maternity stays and type of payment. Uninsured women and those on Medical Assistance were the most likely to have shorter stays from 1985 through 1994, while patients with indemnity and managed care plans had longer stays. However, during the first quarter of 1995, the disparity between payer categories narrowed.

Medical Research

Grafts Using Chest Arteries Improve Survival Following Bypass

Long-term survival is increased following coronary bypass surgery if grafts are performed with a chest artery rather than a leg vein, according to researchers from the Mayo Clinic and other research centers. The researchers recommended in the January 25 *New England Journal of Medicine* that cardiac surgeons use the internal mammary artery to bypass blockages in coronary arteries whenever possible. The most significant improvement comes when the internal mammary artery is used to bypass the left descending coronary artery, said Mayo physician Hartzell Schaff, M.D., in a Twin Cities *Star Tribune* article.

The study, conducted at 15 centers, used questionnaires to compare 4,888 patients who had one or more vein grafts with 749 patients who had a single internal-mammary-artery graft and may or may not have had additional vein grafts. The hazard rate was about the same for both groups after one year; after eight years, the hazard rate increased more rapidly for patients with vein grafts.

Bacteria Causing Granulocytic Ehrlichiosis Isolated

Researchers from the University of Minnesota and three other centers have isolated the bacteria that causes human granulocytic ehrlichiosis, an infection believed to be spread by deer ticks, according to a report in the January 25 *New England Journal of Medicine*. Their research will allow scientists to develop more accurate tests for the infection, study treatments, and determine how common the infection is.

The infection was discovered in 1994 when 12 people from Minnesota and Wisconsin developed high fevers and muscle aches. Tests showed they had low blood counts, alterations in their liver functions, and some form of bacteria growing in their blood cells. Other cases have since been reported in California, Florida, Maryland, Massachusetts, and New York.

Other centers in the study were the Grantsburg Clinic in Grantsburg, Wisconsin; the University of California in Davis; and the University of Maryland in Baltimore.

Mayo Improves Screening for Colon Cancer

Researchers at Mayo Clinic have found a comfortable technique using computerized tomography to screen patients for precancerous polyps and cancer of the colon.

According to their report in

the January *Journal of Gastroenterology*, the technique, called CT colography, detected 30 precancerous polyps in 10 patients. The polyps had been identified with colonoscopy. In addition to saving money, CT colography causes less discomfort and can detect smaller polyps than colonoscopy.

"We now have the opportunity to detect very small polyps, some even smaller than one centimeter in diameter," said Daniel Johnson, M.D., a Mayo radiologist.

The technique uses a helical CT scanner to gather information from scores of x-rays much faster than conventional CT scans. Then computer software developed at Mayo reconstructs images of the colon, providing two-dimensional images that clearly show even small polyps. Researchers said it takes about 10 minutes to reconstruct the images, and they estimated the procedure costs about \$400 to \$500, about half the cost of colonoscopy.

Age and Cancer Growth Rate Are Key in Treating Prostate Cancer

Physicians should consider a patient's age and cancer growth-rate when determining whether to treat or watch a malignant tumor of the prostate gland, according to researchers at the Mayo Clinic in Rochester and the University of Michigan.

Since many more men will die with prostate cancer than of it, the researchers have developed a formula using life expectancy tables as part of the criteria for determining the significance of tumors. Clinically "significant" tumors are dealt with promptly, and those that are clinically "insignificant" are often watched. Other criteria for treating prostate cancer include cancer volume, grade, and the time it takes for the cancer volume to double. Being able to predict small volume, clinically insignificant prostate cancer could preclude surgery and



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radiation, say the researchers in the January 24 *Journal of the American Medical Association*.

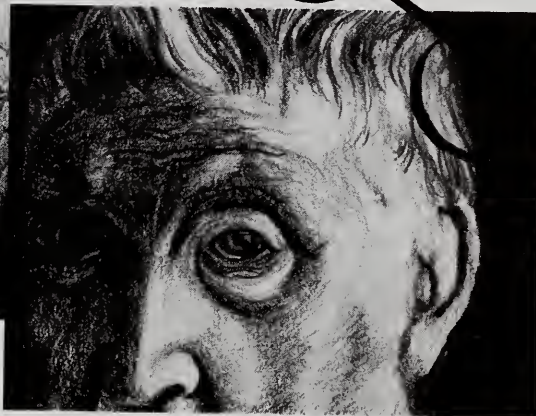
Researchers say that although their definitions theoretically allow the cancer to metastasize in the final years or months of life, this does not necessarily imply that the cancer will become symptomatic (clinically significant). Although 30 percent to 40 percent of men over age 50 have prostate cancer, only 8 percent of cancers become clinically significant.

Previous studies have defined clinically significant prostate cancer based on such factors as the size and stage of the cancer, but they have not considered cancer volume growth rate and patient life expectancy.

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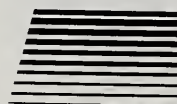
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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

MARCH 1996

Mar. 7 **Annual Gentle Journey Conference: Palliative Medicine's Approach to the Relief of Suffering** Twin Cities Hospices; Sheraton Inn-Midway, St. Paul, MN. CONTACT: Lee Cummins, 1450 Energy Park Drive, St. Paul, MN 55108; 612/232-2600.

Mar. 7-8 **Family Medicine Today** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Mar. 22 **Occupational Medicine Update** St. Paul-Ramsey Medical Center; Sheraton Minneapolis Metrodome, Minneapolis, MN. CONTACT: Sharon Kopp, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3223.

Mar. 22-23 **Advanced Life Support In Obstetrics (ALSO)** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Mar. 28-29 **Critical Care 1996** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

APRIL 1996

Apr. 1-3 **Management Strategies in Complex Congenital Heart Disease** Mayo Foundation; The Pointe Hilton at Squaw Peak, Phoenix, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 11-12 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Apr. 12 **ENT for Primary Care Physicians** St. Paul-Ramsey Medical Center and HealthEast; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 13 **Minnesota Urological Society Spring Seminar: An Update on Pelvic Floor Dysfunction, Urinary Incontinence, and Female Urology** Minnesota Urological Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Apr. 18-19 **Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 19-20 **Adolescent Health Issues in Primary Care** Children's Health Care; Madden's Resort on Gull Lake, Brainerd, MN. CONTACT: Kathy Ingerson, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/813-5884.

Apr. 19-20 **Minnesota Orthopaedic Society 12th Annual Meeting** Minnesota Orthopaedic Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

Mar. 22 **HIV Update** Allina Health System, Children's Health Care, HealthEast, Park Nicollet Foundation/Health System Minnesota, Hennepin County Medical Center MATEC, Minneapolis RMEC, Department of Veterans Affairs, St. Paul-Ramsey Medical Center, and the University of Minnesota; The Metropolitan, Golden Valley, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Sue Burmeister, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3216.

Printed Material: **Physicians' Update: Bloodborne Pathogens** Medical Education Group Learning Systems. CONTACT: MEGLS, Internet address: <http://www.cme.edu>; or call 800/547-0308.

Apr. 25-26 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

Apr. 26 **Twelfth Annual Duluth Heart Conference** Duluth Clinic; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Fifth Avenue Building, Duluth, MN 55805; 218/725-3838.

Apr. 26-27 **Advances in Polycystic Ovary Disease** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 26-27 **Annual Meeting—Minnesota Chapter of the American Academy of Pediatrics** Minnesota Chapter of the American Academy of Pediatrics; Mall of America, Bloomington, MN. CONTACT: Julie Pierce, 1847 131st Lane NW, Minneapolis, MN 55448; 612/757-7805.

M A Y 1 9 9 6

May 4 **Minnesota Society of Pathologists Spring Seminar: A Multidisciplinary Approach to Breast Cancer** Minnesota Society of Pathologists; HCMC, Minneapolis, MN. CONTACT: Jennifer Stendahl, MSP, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

May 17-18 **Allina Pregnancy Care Initiative** Allina Health System; Radisson South, Bloomington, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

May 17-18 **Using Computers to Help Manage Clinical Information** American College of Physicians and Allina Health System; Earle Brown Continuing Education Center, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

J U N E 1 9 9 6

June 12-15 **Sixtieth Annual Course on Advances in Trauma and Critical Care Surgery** Department of Surgery, University of Minnesota Medical School; University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 13-15 **Minimally Invasive Coronary Bypass Surgery Symposium** Minneapolis Heart Institute Foundation; Hyatt Regency, Minneapolis, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

June 25-29 **Internal Medicine 1996: Advances and Controversies** Mayo Clinic and the Department of Medicine, Royal College of Surgeons, Ireland Medical School; Dublin, Ireland. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

A U G U S T 1 9 9 6

Aug. 2-3 **Bleeding and Thrombosing Diseases: The Basics and Beyond** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Aug. 8-10 **Third Annual Symposium on Biomedical, Biopharmaceutical, and Clinical Applications of Capillary Electrophoresis** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Aug. 24-27 **International Symposium on Radioiodine** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

S E P T E M B E R 1 9 9 6

Sept. 9-10 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

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Family Practice, Ob/Gyn to join progressive 14-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*2/96-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Olmsted Medical Group is seeking BC/BE physicians in the following specialties: family medicine and ob/gyn. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. In addition to the main office in Rochester, the group operates nine branch offices in southeastern Minnesota and staffs affiliate hospital emergency room. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Group, Attn: Susan Schuett, 210 Ninth Street SE, Rochester, MN 55904. (9/95-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine (oncology, pulmonology, and nephrology), family practice, ophthalmology, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (2/96-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

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Internal Medicine: The Fergus Falls Medical Group's five-member Internal Medicine Department is seeking a BC/BE general internal medicine physician as well as those with subspecialty training/interest in oncology, pulmonology, and nephrology. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066.

(9/95-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Family Physicians sought for rural and midsize communities in Iowa, Minnesota, North Dakota, South Dakota, and Wisconsin. Contact VHA North Central, 3600 West 80th Street, Suite 550, Minneapolis, MN 55431. Call collect: 612/896-3492, or fax 612/896-3425. Ask for Jerry Hess. 3-3/96

Cardiologist—St. Cloud: CentraCare Clinic, a growing 53-physician multispecialty group based in St. Cloud, seeks an interventional or non-interventional cardiologist to join our group of eight cardiologists. This is a unique opportunity to practice high-quality cardiology in a beautiful, small-city setting. With three area universities, excellent schools, and abundant recreational opportunities, St. Cloud

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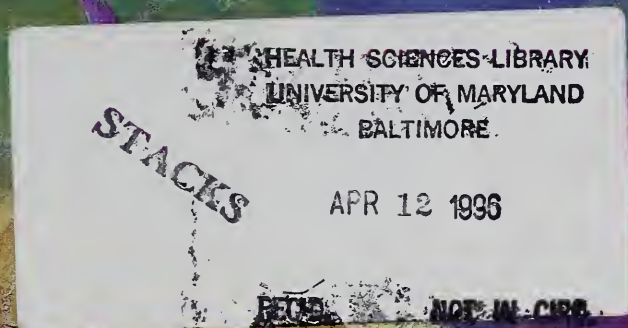
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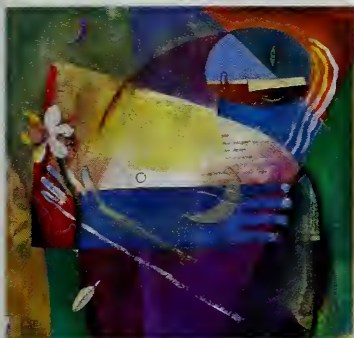
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Cancer Research and Treatment

When Money, Morals, and Medical Science Converge

Charles R. Meyer, M.D.

Cancer itself is turning into a soluble problem. ... A genuine high medical technology will make an enormous difference to medical practice in the decades ahead, provided that we keep the basic biomedical sciences going and couple them as congenially as possible to clinical research.

—Lewis Thomas,
"The Fragile Species"



"Few specialties see basic science feed clinical practice as richly as oncology."

Few observers of science have written with the grace and wisdom of Lewis Thomas. Viewing cancer from leading-edge research at Memorial Sloan-Kettering, he saw medical science move from the 1960s' guesswork about the causes of cancer to the 1990s' revelations about cancer's genetic and viral etiologies. What is the state of the science of oncology today? Spurred by the appointment of John Kersey, M.D., as director of the University of Minnesota Cancer Center (see profile, page 6), this month's *Minnesota Medicine* looks at the coupling and the clash of medical science with medical practice in oncology.

Not many specialties see basic science feed clinical practice as richly as oncology. Oncogenes, cancer immunology, and recombinant DNA have moved from mere concepts to vital tools for understanding cancer and devising new treatments. The review article by Ramsay et al. on bone marrow transplantation (page 23) portrays researchers manipulating receptors and genes. Genealogy acquires new meaning in the tracking of genetic cancers described in the case report by Hilden et al. (page 29). Genes aren't just for test tubes anymore; they've crept into the clinic. Textbooks and reviews of hematology and oncology team with the San-

skrit of chromosome and receptor terminology. To keep up in these fields, we must speak the language of the molecular biologist.

Despite the progress, the convergence of oncology research and clinical medicine is in some ways more like a collision. First, today's oncology wrestles with the two big questions confronting tomorrow's medicine—money and morals. Research costs money; appropriations to the National Cancer Institute for 1995 were \$2.14 billion. Applying research also costs money; bone marrow transplants can cost \$50,000 to \$200,000 or more—big bucks in a time of monetary screw-tightening.

What gets paid for, who pays for these advances, and at what stage of development? These questions are addressed in Karen Gervais' article on mandated coverage of medical treatments (page 52). Public and private grants have traditionally funded medical research and investigation. The transition of investigational evaluation into accepted clinical practice

has always been a murky slide. And the connection between accepted clinical practice and third-party payment for new procedures is also a turbid passage, as Medicare and other payers capriciously and grudgingly agree to pay. Medicine is ambiguous about many issues of accepted medical practice. Because medicine is ambiguous, cost-wary third-party payers refuse to cover the questionable. Because third-party payers won't pay for high-visibility items, legislatures intercede—for reasons based more on PR and politics than medicine and science. Money matters become moral matters when lives are threatened by withholding money. We need to look at the ethics of these decisions, not just the economics.

The other spot in the sheen of high-tech oncology and hematology is the reality of daily practice, which can burn out its practitioners (see this month's feature story, page 12). Oncology still involves mostly pushing poisons, much as has been done since the 1960s. It's done with more precision, and it has achieved some remarkable results, particularly with hematological malignancies. But the paradigm is the same: kill as many bad cells as you can without killing so many good cells that you kill or damage the organism.

Lewis Thomas died in 1993. Ironically, he died of lymphoma. The juxtaposition of his hopeful writings about cancer research and treatment with his death from a hematological malignancy reflects the state of oncology today. We've come a long way, but will we continue to advance basic science's understanding of cancer toward its cure? The answer depends on whether we can afford to and whether we can handle the ethical conundrums we encounter along the way.

MM

Building Bridges to Combat Cancer

*University of
Minnesota Cancer
Center Director
John Kersey, M.D.,
wages war on
cancer by uniting
faculty who have
wide-ranging
research interests.*

By Miriam
K. Feldman

There was a time when John Kersey had his mind set on becoming a family practitioner in rural Minnesota. But a year spent studying the immune system of mice as a University of Minnesota medical student convinced him to devote his career to cancer research instead. Last year, Kersey was honored for the path he

chose, when he received the Medical Alley Lifetime Achievement Award. Although the award has a ring of closure to it, Kersey's career is hardly over. He can foresee a day, perhaps five years from now, when he might have more time for fishing and skiing, but, for now, he isn't quite ready to take down his shingle.

Kersey is in the throes of a busy career. He recently was named director of the University of Minnesota Cancer Center, after serving as acting director since the center's establishment in 1991. He sees patients. He oversees a group of graduate students and postdocs doing leukemia research and developing genetically targeted molecules to treat cancer. And he is a professor in the departments of Pediatrics, Therapeutic Radiology/Radiation Oncology, and Laboratory Medicine and Pathology, where he holds the Children's Cancer Research Fund Land Grant Chair, an endowed professorship.

Kersey is known as a pioneer and leader in research and development in the field of human leukemia, lymphoma, and bone marrow transplantation. He and his colleagues performed the world's first successful bone marrow transplant for lymphoma in 1975, just two years after joining the University of Minnesota's faculty. In the early '80s, he helped develop the earliest monoclonal anti-

bodies for the study of leukemia, and he pioneered the subsequent use of these antibodies for cleansing bone marrow of leukemia cells prior to reinfusion of the patient's own bone marrow. The results of his work have been published in more than 400 papers.

It should come as no surprise, then, that Kersey has garnered more awards than a Triple Crown winner. Aside from the Medical Alley award, he has been named an outstanding investigator by the National Cancer Institute and has been honored by the American Society of Hematology and the Leukemia Society.

The object of all this adulation operates out of a Spartan office, with just enough room for a desk, a few chairs, a book case crammed with journals, and two space heaters, which happened to be working overtime on the morning he had set aside for this interview.

No doubt Kersey is looking forward to moving into the university's new four-story Cancer Center Research Building (the dedication ceremony marking its official opening was held March 30)—not just because it's likely to be warmer. Rather, the building will be the hub of an interdisciplinary team of researchers working together to tackle an illness that is expected to surpass heart dis-

ease as the leading cause of death by the turn of the century.

Kersey has worked since the center was created in 1991 to integrate cancer research, education, and treatment efforts at the university, joining sometimes disparate groups in a single unit. Today, the center includes more than 200 faculty in various schools and departments with a common mission: preventing, diagnosing, and treating cancer. The research building gives the Cancer Center a central home.

As Kersey explains, a team approach to cancer is more important than ever. "Twenty years ago, we could each work in our own separate buildings and laboratories and not communicate. You can't do that anymore," he says. "Understanding how cancer develops requires various disciplines working together."

The challenge, of course, is drawing those disciplines together. "People in universities have a tendency to go in our own directions and be very free spirits and be creative. That's good," says Kersey. "But when it comes to cancer research, people have to work together because it's so complex."

Kersey is known as a bridge builder for his successful efforts thus far. "I like to bring people together. Getting us all to work together on a complex project is exciting. It's the way we make progress," he says. Kersey has had the fortune of seeing dramatic progress in the particular diseases he has tackled. Two decades ago, the cure rate for childhood leukemia was 10 percent; today it is 70 percent. He is buoyed by such success, and finds it encouraging that other researchers are applying some of the principles learned in the treatment of leukemias and lymphomas to more confounding diseases, such as breast and

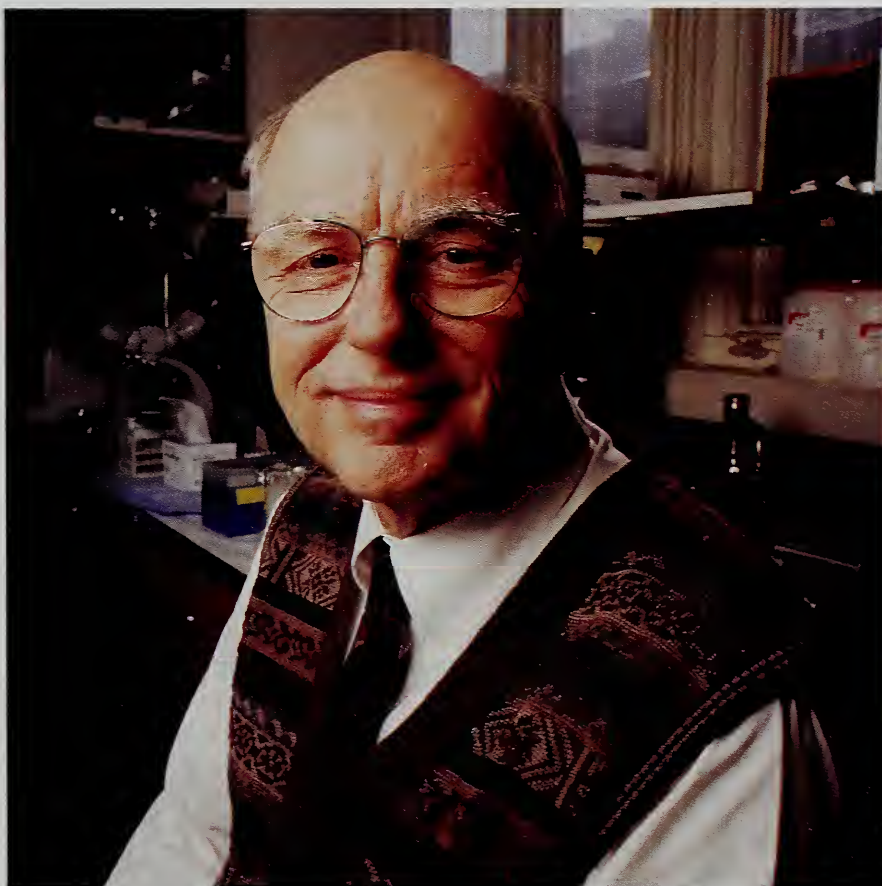
prostate cancers. "It makes me very hopeful that we'll show significant progress in those other diseases, particularly the solid tumors," he says.

Despite its gains, cancer research is painstakingly slow, the results measured in five-year increments at best. There are no shouts of "Eureka!" in a cancer researcher's lab. This may explain why Kersey is mildly self-effacing when asked to speak about his pioneering accomplishments.

It was 1975 when Kersey and the team (which included Norma Ramsay, M.D., William Krivit, M.D., and Mark Nesbit, M.D.) performed the world's first successful bone marrow transplant to treat lymphoma. That transplant came on the heels of the world's first bone marrow transplant for a genetic immune deficiency disorder, done at

*"Understanding
how cancer develops
requires various
disciplines working
together."*

—John Kersey, M.D.



PHOTOGRAPH BY BRUCE BAIRD

"Gene therapy for cancer is a ways away. I think it's probably oversold. If you have a mistake in the cell, it's hard to do something about it."

—John Kersey, M.D.

the university in 1968. "We said, 'Why don't we consider doing high-dose chemotherapy and radiation therapy, followed by bone marrow transplantation to treat lymphoma?'" he recalls.

Today, bone marrow transplantation is standard practice; more than 2,000 procedures have been conducted at the University of Minnesota. And Dave Stahl, the recipient of Kersey's first transplant to treat lymphoma 20 years ago, was present as Kersey received the Medical Alley award. At the time of the transplant, Kersey would have been unable to predict such a rosy future. Early on, it was clear that the bone marrow took, he says. "But like all cancer, you wait five years to say somebody is cured."

When he accepted the Medical Alley award, Kersey mused on a future in which cancer patients are treated with more targeted therapies, or even better, never develop cancer in the first place. Kersey foresees the targeted treatments becoming reality, but he concedes that it's hard to imagine cancer's eradication.

Nevertheless, he insists that certain cancers are preventable, and to make his point, he pulls out graphs that show the dramatic increase in lung cancer since 1930. "That's entirely related to smoking," he explains, as he moves his finger up the steeply sloping diagonal lines. "One of the most common cancers can be prevented."

Certain other cancers, including colon and rectal cancer, are to an extent preventable through dietary changes, he adds. And some cancers won't be preventable "because cancer at the level of the cell is a mistake in the genetics of the cell," Kersey explains.

The Cancer Center's familial cancer program, with its emphasis on genetic screening, will advance the understanding of such complex issues (see related article on familial cancer, page 29). But Kersey notes that while

scientists have gotten very good at detecting genetic mistakes, fixing them is a different matter. "Gene therapy for cancer is a ways away," he says. "I think it's probably oversold. If you have a mistake in the cell, it's hard to do something about it."

We can, however, look forward to improved treatments, such as the therapeutic agents known as "magic bullets"—toxic agents attached to antibodies that are aimed directly at the cancer cell—which are being developed in Kersey's lab.

"It's been exciting to do that work," Kersey says, noting that 10 years ago, his lab, with the help of Daniel Vallera, M.D., and Fatih Uckun, M.D., was the first to use antibodies with the toxic agent ricin to treat leukemia and lymphoma. That treatment is now being applied directly to patients in an experimental program.

Because experimental research and treatment is the hallmark of the University of Minnesota Cancer Center (although it offers all cancer treatment programs), Kersey welcomes the university's planned merger with Fairview Health System, saying it will give the Cancer Center an opportunity to disseminate new treatments into the community. In fact, when combined with Fairview, the university will have the largest cancer market share of any medical system in the state. "We can't just function as an island waiting for patients to come here for experimental treatment programs. We have to have interaction with more patients who have cancer," he says.

"I'd like to see this Cancer Center become the focal point where we make significant advances in research, education, and treatment. For me, that's an exciting possibility for the next five years." MM

Miriam K. Feldman is a free-lance writer in Minneapolis and a frequent contributor to Minnesota Medicine.

Where knowledge and practice interact



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DIAGNOSIS

*Implosion.
With the diagnosis
of breast cancer, this
wife, mother, and
scientist felt her life fall
inward in chaotic piles
of rubble—careful
constructs of life twisted
in on themselves.*

DEBORAH PETERSEN

My life changed one day with a sudden, painful lump in my breast. Ironically, it bothered me only when I wore my sports bra to exercise. I was 33, extremely healthy, and Dale, my M.D. husband said, "It feels cystic." My ob/gyn said, "This doesn't feel like any cancer I've seen," but ordered a mammogram and biopsy because "I've seen too many women diagnosed in their early 30s recently—one was even pregnant." My bottom line was simple: just take it out.

The mammogram showed small areas of calcification, making it somewhat suspicious, though no tumor was seen. Probably benign, cystic disease; a needle localization biopsy was recommended to be sure. Before the biopsy, a fine silver needle was

placed in my breast marking the questionable tissue for my surgeon, Tom. It had been a tedious process: I had lain supine on a padded table, muscles stiffening, breast dangling through a hole like the broken muffler of a car on a hoist, while others scurried beneath me. I eyed my skewered breast, a truly bizarre shish-kebab, as I waited for Tom to enter the clinic's surgery suite.

Tom was my age, warm, friendly—qualities I hadn't typically associated with the students in my medical school classes who had fit and possibly been the inspiration for the axiom "surgeons are assholes." Tom and I chatted amiably about my hus-



ILLUSTRATION BY ANDREW POWELL

band, one of the clinic's internists, and gossiped with the nurse about upcoming clinic and hospital social events. Lying down on the surgery table was no more difficult than falling into my own bed.

Curiosity overcoming common sense, I watched my own biopsy reflected in Tom's glasses. Strange, stony, raspy sounds as he wrested the tissue from my breast for pathology. In my years of graduate scientific training, I had never heard such a sound. I innocently asked what Tom thought. "I'll be straight up with you—it's not good. It could be benign, but only pathology will be able to tell us."

Waiting for results near the windows of the fifth-floor office, I noticed the gentle lush bounty of spring. The brilliant daffodils curtsied to the blustery wind, then bobbed and weaved to escape its flirty embrace. Birds flitted sans souci on the rich emerald grass, at last confident of their next meal after winter's bare larder. I prayed for everything to be OK, suddenly embarrassed that I hadn't been to church for a long while. My intellect calmly stated it wasn't time to worry yet; there would be time enough for that if the news were bad. The wait grew longer. Back in the examining room, I knew the truth before it left Tom's lips.

IMPLOSION LIKE A BUILDING DEMOLISHED on a city block, falling inward in chaotic piles of rubble, the careful constructs of my life grotesquely twisted in on themselves, leaving a huddled heap of devastation. In an instant, I became an adult, transformed by possibilities never considered, stored deep in my brain's cache of fearsome dark things. Monsters in the closet, devils in the basement, and creepy things lurking under the bed. Pinned to my chair with G-force seriousness, I pitched headlong through and beyond my own 30s. Young parenthood problems melded with those of late middle age. I became, within myself, a sandwich generation.

Poised scientist, I assailed Tom with questions. I paged my husband. As we waited for him to call, Tom confessed in a gentle tone that he sometimes had nightmares of his own wife, young and healthy like me, being diagnosed with breast cancer. He was sincere and caring, and didn't leave me alone for a moment. We gazed at the picture of his children on the desk, the youngest strikingly similar to my own then year-old son.

I returned downstairs to X-ray, where I'd begun

my visit short hours ago, no longer the same person. I waited for a chest x-ray, feeling betrayed by the needle localization biopsy. The radiologist had said, "Ninety percent of these lumps in women your age are benign." I had babbled in return all the self-empowering phrases from women's magazines: "I want to know. I couldn't live with myself if I didn't know." And now that I did know, I truly understood the enormity of the phrase "ignorance is bliss." At the same time, I thought hopefully about treatment and cure.

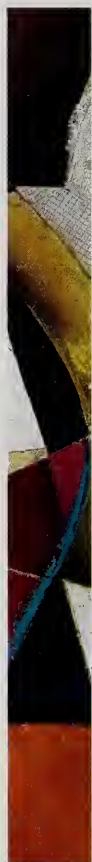
THE WOMEN'S SUB-WAITING ROOM in X-ray was filled with middle-aged women, gowns tied in front for mammograms. They placidly read magazines while a video overhead droned about breast cancer in a cultured, paternalistic, yet nauseatingly feminine voice. No one seemed to be listening but me. The litany of risk factors (I had none), the importance of a baseline mammogram at 35 (will I be alive then?), and the fact that the procedure doesn't hurt (at least physically—the mental anguish of diagnosis is much too scary to mention). The other women continued to read, ewes in the flock of the worried well, seemingly confident in early detection, and assured of cure. Or was their nonchalance a cover for abject terror in the pits of their stomachs? I wanted to jump up and scream that they could all go home now; the clinic had met its quota of breast cancer diagnoses for today, and it was me. I envied their innocence, knowing, but healthily denying, that a routine test could be a viper, striking when one least expects.

My husband and I met at home. Tears mingled on our faces as we embraced, knowing we stood together on life's razor edge, one side the chasm of uncertain treatment in hopes of cure, on the other the certain abyss of death. A heap of rubble amidst undisturbed, sturdy buildings. Implosion. **MM**

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Deborah Petersen died last May at age 36 following a three-year battle with breast cancer. This essay is one in a series she wrote, hoping to publish the collection as a book to help other women cope with the emotional struggles of a cancer diagnosis. Deborah Petersen was a toxicologist at the Minnesota Department of Health. She is survived by her husband, Dale Petersen, M.D., an internist at Park Nicollet Clinic, and their 5-year-old son, Jay.

Running on empty



Recognizing the symptoms of burnout, managing stress, and seeking support can help physicians feel fulfilled instead of overwhelmed.



ILLUSTRATION BY ANDREW POWELL

There is no such thing as a predictable day for oncologist P.J. Flynn, M.D., of Minnesota Hematology Oncology in Minneapolis. A morning that starts out quietly can be overwhelming by noon, with several patients arriving at the hospital, and others **By Katie Colón**

newly diagnosed with cancer wanting to be seen right away. More often than not, the long days run into the evening, as Flynn returns calls to patients and families anxiously awaiting test results or wanting more information. They are patients who cannot wait until next week; their physical and emotional needs require prompt attention. While treatment will cure some of them, Flynn spends much of his time administering palliative care to those with advanced malignancy—patients who will die of cancer despite the latest medical and technological advances.

Like their counterparts in the emergency department or other intensive care environments, oncologists treat people who are seriously ill or dying. This takes a toll on the physicians' emotional, physical, and even spiritual health, says Edward Creagan, M.D., American Cancer Society oncologist at the Mayo Clinic in Rochester. If left unchecked, he says, the stress can lead to burnout—often described as frustration or a sense of failure in one's work.

Although studies have documented a significant rate of burnout among various groups of health care professionals, including oncologists and critical care physicians, the issue is rarely discussed in medical practices. Physicians are expected to keep their emotions in check, their boundaries straight, and their practices under control. But what happens when frustration or a sense of failure sets in? Or when physicians begin to feel overwhelmed?

"The level of intensity and time involved in oncology is very high and very constant," says Mark Sborov, M.D., medical oncologist on staff at Fairview Southdale Hospital in Edina. "The people we treat are always in a state of disrepair, and the physical and emotional demands [for the physician] are significant. [Oncology] is an exciting and fascinating field, but it can also be physically and emotionally exhausting. There are many days when you're running on empty."

In a 1992 random survey of 1,000 physicians who subscribed to the *Journal of Clinical Oncology*, 56 percent of the 598 respondents reported experiencing some degree of burnout in their professional lives.¹ The survey results indicated that an increasing number of medical oncologists are finding themselves acting as their patients' primary physicians; they are spending more time on palliative care or symptom management than on active treatment. The data also suggested that coping with problems related to palliative care for terminal patients is one of the greatest contributing factors to burnout.

Physicians who spent the majority of their time seeing patients (as opposed to doing research or teaching) reported the highest rate of burnout. For example, 66 percent of the physicians who practiced oncology and internal medicine said they had experienced burnout, while the burnout rate for institution- or university-based oncologists was 47 percent.

When Cure Is Elusive

Shifting from a curative care load to a palliative care load is difficult, says Creagan. Physicians are trained to cure the patient, but this happens very infrequently when patients have advanced, solid tumors.

"When you first start out, you think you're going to cure everybody," says George Adams, M.D., area leader of the Head and Neck Cancer Program and head of the Otolaryngology Department at the University of Minnesota. "But after you are in [patient care] for a long time, you realize that the success rate is not as good as you had anticipated."

In patients with very advanced head and neck cancer, for example, cancer will recur in 50 percent following the surgical removal of their tumor, even with postoperative radiation, says Adams. Many physicians simply have a hard time accepting this, he says. "The surgeon feels terrible if the cancer recurs locally, and often feels a personal sense of failure."


"If oncologists believe their mission is cure," says Creagan, "they will be defeated at every turn. If their spiritual health is not in order, it will come tumbling



down like a house of cards with each progression of the [patient's] disease."

Swing Shifts and Trauma Care

Like oncologists, emergency physicians often feel the psychological and physiological stresses of high-intensity patient care coupled with long hours, says Timothy Crimmins, M.D., emergency physician at Hennepin County Medical Center. In a department that is open 24 hours a day, seven days a week, the physiological stress of working swing shifts is a real issue, he says. Regular interruptions in a person's biorhythms can lead not only to a feeling of jet lag, but can be a significant contributor to the feeling of



"Oncology is an exciting and fascinating field, but it can also be physically and emotionally exhausting. There are many days when you're running on empty."

—MARK SBOROV, M.D.



burnout if the person is not careful to get a certain amount of "anchor sleep" each day.

Likewise, the psychological stressors in the emergency department are many, says Crimmins, who also chairs the MMA Board of Trustees. Emergency physicians face the risk of HIV infection, assault when dealing with gang members or gun-related trauma, and the constant threat of professional liability—the possibility that a patient's family may blame the doctor for a bad outcome. On any given shift, there is no control over the number of patients arriving at the hospital or the types of injuries or illnesses that will need attention. Work can be a roller coaster of emotional highs and lows.

"It's a great feeling when you can offer a patient care and comfort or save a life," says Wayne Hass, M.D., interim chief of the Department of Emergency Medicine at St. Paul-Ramsey Medical Center. "But then you may suddenly find yourself in the situation where you are

Critical Incident Stress Debriefings

They are firefighters, police officers, paramedics, emergency department staff, and mental health workers. Together they make up the 70-member Critical Incident Stress Debriefing (CISD) team of the metro region, trained to provide peer counseling to fellow rescue and emergency workers following traumatic incidents.

"When someone recognizes that they have just been involved in a critical incident, they can call the 24-hour CISD hotline (handled by Medic Control at Hennepin County Medical Center) to request a debriefing," says Charlie Cook, L.S.W., program manager for the metro region Critical Incident Stress Management Team.

A debriefing might be called when, for example, rescue workers need help dealing with a child's death or severe injury following a motor vehicle accident or abuse, or a fatal fire or line-of-duty death. The debriefing usually occurs within 24 to 72 hours of the critical event and offers participants an opportunity to talk together about their feelings of sadness, frustration, or even anger over what has occurred, Cook explains. (In some instances, a more immediate "defusing" meeting occurs within hours of the event to offer people an informal chance to talk before the debriefing.)

The debriefing team generally consists of three to five peer counselors and one mental health worker. In addition to helping participants talk about their feelings, team members provide education about critical incidents and how they affect people's lives, and they offer strategies for managing stress. Peer counselors also can provide one-on-one counseling to individuals who may want to talk further at a later date.

About 50 debriefings occur in the metro region each year. Other CISD teams offer debriefings in each of Minnesota's eight emergency medical services regions, and also have 24-hour hotlines.

Rob Carlson, senior planning analyst for the Hennepin County Community Health Department and a former paramedic, coordinated the first metro region CISD team in the late 1980s. What began as a peer counseling team for paramedics quickly grew to include all types of emergency response workers and emergency department nurses and staff. A few physicians also have participated, although they are less likely than others to attend debriefings, Cook says.

Recently, Brian Mahoney, M.D., emergency physician at Hennepin County Medical Center, completed the 10-hour training to become part of the CISD metro team.

"I think there is a real need [for the debriefings],

forced to walk in a room after working on someone and tell a young couple that their child has died.”

The family often becomes your second patient, Hass explains. “Sometimes relatives feel responsible in different ways for a bad outcome, and you don’t want to put any additional feelings of guilt on them. They probably already realize that it was foolish to let a 13-year-old ride a snowmobile at night, going 90 miles an hour, with a 6-year-old riding behind.” In dealing with the family, the physician may also become distressed, Hass says.

“It is very difficult to tell a family member that someone who was totally normal an hour before has died, or is now a quadriplegic,” Crimmins says. The devastation the family feels is acute and sudden. Unlike the families of patients with terminal illnesses, these families have had no time to prepare for the loss. In their shock and grief, they often blame the physician for what has happened, he says.

and I would like to be able to do my part,” he says. In July, Mahoney will take over as medical director of HCMC’s ambulance service. He views his role on the CISD team as an opportunity to share in and better understand the experiences of the 110 medics he will be supervising.

“I am a real advocate of the notion of being a culture of caring and looking out for one another,” says Mahoney. “We all experience critical stress events. I certainly have.”

Before joining the team, Mahoney heard of instances when peer counselors felt a physician participant would have been helpful. In one case, rescue workers were distressed when a victim died before they could get him to the hospital. “A physician may have been able to help them understand that the person was mortally wounded and that nothing they could have done would have saved him—that they didn’t have to feel guilty,” Mahoney says.

Although he acknowledges that many physicians are reticent about expressing their emotions, Mahoney believes that they could benefit from greater participation in CISDs. “In no way are physicians immune to the horrors [of traumatic incidents],” he says. By joining the CISD team, he hopes to help fellow physicians, as well as emergency medics.

—KC

Burdensome Bureaucracy

In today’s managed care environment, physicians face additional stresses from bureaucracy, with managed care organizations often requiring physicians to get approval for treatments.

In the last four or five years, insurance companies have taken on the role of deciding what is and isn’t an appropriate treatment for a patient, says Flynn. “It’s very frustrating to be called by someone who can’t even spell the [name of the] treatment, and have them say, ‘I don’t think that [treatment] is a good idea, Doctor.’ You’re not talking to someone on the other end who is knowledgeable, but to someone with a checklist. I don’t think physicians should have to spend time dealing with that stuff. It certainly doesn’t help the burnout sensation.”

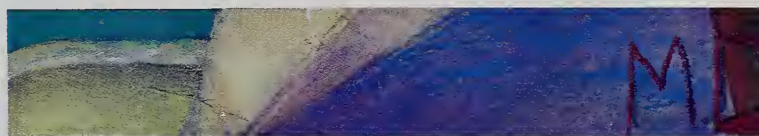
Tony Smithson, pediatric oncologist at the Mayo Clinic, agrees that managed care’s bottom-line perspective leads to frustration for physicians. One more form to fill out. Rules being made by people who don’t understand the physician’s job.

As a pediatric oncologist, Smithson says the patient care aspect of his work is not a source of stress. “I relate to wonderful children and am privileged to be involved in their cure.” (Today’s survival rates for children with cancer are about 70 percent nationally, much higher than for older patients.) Rather, the frustration comes from spending time each week writing letters to explain to insurance companies and managed care organizations why a certain treatment was necessary for a patient, he says.

When Burnout Strikes

Physicians have little control over the stresses that can contribute to professional burnout, Creagan said in a seminar lecture on survival strategies for avoiding professional burnout. They have three essential options: flee, fight, or flow.² He suggests physicians learn to “go with the flow.”

The physician who flees the burnout situation gradually disengages from clinical practice, says Creagan. For



the majority of physicians, the economic liability of divesting themselves from medicine altogether may be too great. More often, they refocus their energies toward research or more administrative responsibilities.

Adams has seen the phenomenon affect a few colleagues within the ranks of head and neck surgery over

the years. Once primarily involved in tumor resection and patient follow-up, they slowly distanced themselves from direct patient care.

"They don't talk about why. But you begin to see them changing their practice," Adams says. Some physicians move into more administrative roles; others change the focus of their practice to reconstructive surgery, where patient contact is short term and the surgeon has no further responsibility for the patient.

Other physicians flee the stress of patient care by going into emotional isolation, says Creagan. They take on a "robotic demeanor, maintaining black-and-white relationships with their patients." This clearly affects physicians' relationships with their patients and their ability to help patients deal with emotional issues, including those of death and dying.

Physicians who struggle with disillusionment "transform from caring to apathetic individuals; they replace

"It is unreasonable to expect that any one individual can provide for the needs of every patient."

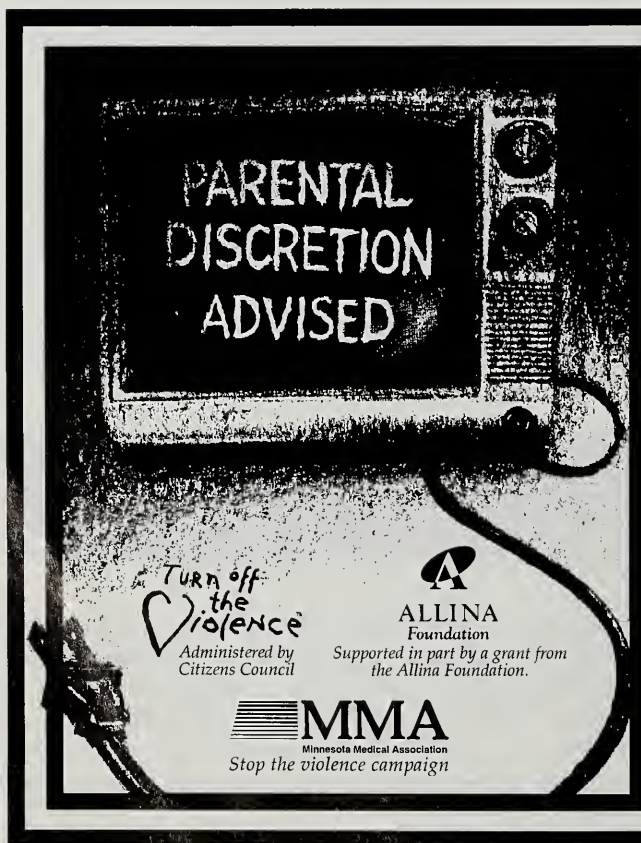
—EDWARD CREAGAN, M.D.

commitment and compassion with aloofness and emotional indifference; and they exchange openness and warmth for a protective, defensive, and self-serving posture," Creagan writes in a 1993 *Mayo Clinic Proceedings* article.

Some physicians flee by turning to medications or alcohol, says Mayo psychiatrist Robert Morse, M.D., a widely recognized expert in physician

addictions. Often, physicians experiencing emotional tension, fatigue, and frustration are unaware that these are symptoms of burnout; they only know they do not feel well, says Morse. To feel better, some physicians may try prescription drugs.

Although Morse believes burnout is often used as an excuse for substance abuse, he also believes burnout can lead to drug or alcohol use and eventual addiction. "Everybody is vulnerable to mental health problems," says Morse. "It's more a matter of circumstances than of whether or not it can happen."



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"The issue of vulnerability is not emphasized enough to young medical students," Morse adds. "Somehow they think they don't have to worry about the occasional use of a tranquilizer or narcotic. If they can be convinced they also are vulnerable, it may reduce the tendency to get into trouble."

Physicians who choose to fight the reality of their situation don't recognize their own limitations, or the limitations of treatment, and often can't come to grips with the dying process, says Creagan. The result is usually frustration, irritation, and a tendency to come unglued at even the most trivial nuisances, he says. "If they don't learn that there are limits to what [physicians] can do for their patients, they will end up with cardiac problems, ulcers, or in the psychiatric ward."

People don't always recognize the symptoms of burnout, says Crimmins. "If a doctor is becoming increasingly moody or irritable over time, he may be told to get a life, change his attitude, or snap out of it." Instead of judging, says Crimmins, we need to get to the root cause of the behavior. Does an elderly patient remind the physician of his father? Did an AIDS patient who died remind him of his brother? Or did a baby's death or a gang killing cause distress?

Preventing Burnout

Physicians can take many steps to avoid burnout. In addition to Creagan's suggestion to "go with the flow"—which entails learning to accept death as a part of life—physicians should recognize their limitations, maintain balance in their personal lives, and pay attention to their emotions.

Learn to accept death

"Going with the flow," or being realistic about a patient's situation, is the most "constructive, positive, and creative tool a physician can have" to deal with the stresses surrounding the care of seriously ill or dying patients, Creagan says. When cure is no longer a realistic goal, doctors can "reorganize their mission to walk with the patient and family, to make their remaining time as comfortable and creative as possible."

Issues of spirituality, immortality, and meaning of life will come up in almost every case, Creagan says. "I have yet to see a patient who doesn't believe in some transcendental force that they reach out for. Whether it is Christ, Buddha, Mohammed, or a higher power, most patients have verbalized some yearning for transcendental support." The physician's own belief in an afterlife is

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a profound comfort when it comes to seeing a patient and family through the dying process, Creagan says.

"There are some days when relating to God is the only thing I have," says Tony Smithson. "You have to have a relationship that is a personal acknowledgment of the spiritual side of yourself."

Recognize your limitations

In addition to having realistic expectations about treating or curing a patient, physicians need to recognize their own professional and emotional limitations, says Creagan. In his seminar materials on burnout survival strategies, he writes, "It is unreasonable to expect that any one individual can provide for the needs of every patient."² Physicians need to set priorities, freeing themselves to focus on important tasks by delegating other responsibilities.

Smithson believes it is important for physicians to say no to some of the less critical demands of their work. "You have to make choices; you can't go to every meeting. It's each person's individual decision and responsibility to keep the balance in their lives."

Maintain balance

Whether it is running, sailing, painting, or fishing, a

creative diversion outside work is key to a person's spiritual well-being, says Creagan. It is also essential to maintain a healthy lifestyle by exercising, eating properly, getting enough sleep, and avoiding the dangers of alcohol and self-medication.

High on the physician's list of priorities, Smithson adds, should be devoting time to personal relationships. "You have to be honest and generous with the time you give your family and recognize that your responsibilities at home don't stop when you walk through the door of your clinic each day."

Pay attention to emotions

Physicians must pay attention to their emotions and stress levels, says psychologist Harry Ireton, Ph.D., of the University of Minnesota Department of Family Practice and Community Health. "Physicians need to take their own pulse. They need to stop dead in their tracks, in the middle of whatever they're doing, look around and see what's happening [in their lives]. If they find they are on overload, they should try to get away for a few days—take some vacation time, suggests Ireton, who works with family practice and pediatric residents to address the stresses they face as physicians. *continued*

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"It is absolutely essential when I get away from work, that I get away completely," says Fairview Southdale's Sborov, who adds that keeping physically active and maintaining outside relationships renews his energy, enabling him to give his best to each of his patients.

Working constantly with patients who are critically ill or dying can be very "eroding" especially if physicians do not have adequate support from peers and colleagues, says Ireton. "But many physicians don't give themselves permission to turn to other people for support or to be vulnerable or dependent on someone else. It is almost anathema."

Suppressing emotion is part of the coping mechanism for physicians in high-intensity and emergency environments, Ireton says. But keeping those emotions inside adds to the level of stress and can create a sense of isolation.

Sharing common concerns with a caring colleague can also help relieve stress and enhance conflict resolu-

tion, writes Creagan. Talking with someone can provide insights and understanding that may not be available to the person who decides to walk the road alone.

"We cannot give what we do not have," Creagan says. "If we are spiritually and emotionally depleted, we cannot reach out to help others. Ultimately, we are only as capable of caring for others to the extent that we are capable of caring for ourselves." MM

Katie Colón is a Minneapolis free-lance writer.

REFERENCES

1. Whipple DA, Canellos GP. Burnout syndrome in the practice of oncology: results of a random survey of 1,000 oncologists. *J Clin Oncol* 1991;9:1916-20.
2. Creagan ET. Professional burnout—seven secrets of successful survival strategies. Mayo Foundation Selected Topics in Internal Medicine [Seminar handout]. February 4-8, 1995. Silverado Country Club and Resort, Napa Valley, California.

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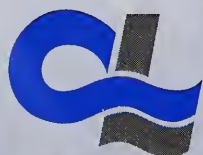
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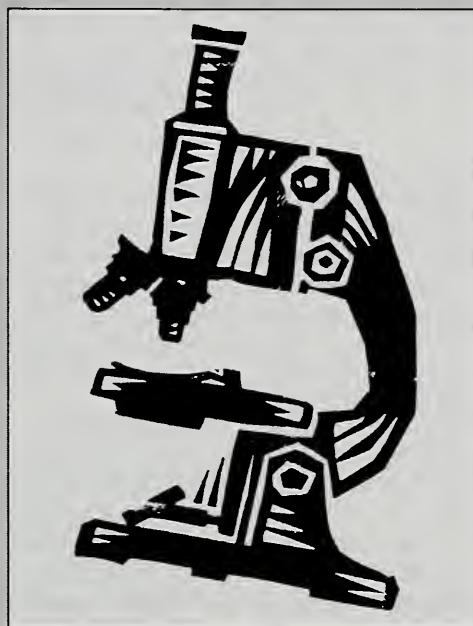
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2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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Bone Marrow Transplantation

New Strategies for Treating Malignant Disease

Norma K.C. Ramsay, M.D., Stella Davies, M.B.B.S., Ph.D.,
John Wagner, M.D., Elizabeth McGough, M.H.A., Philip B. McGlave, M.D.

ABSTRACT

In the years since the world's first successful bone marrow transplant (BMT) was performed at the University of Minnesota in 1968, the field of bone marrow transplantation has evolved rapidly. Stem cells can be obtained from a variety of sources: bone marrow from a matched sibling or unrelated donor (allogeneic transplant), bone marrow or peripheral blood from the patient (autologous transplant), and umbilical cord blood that was collected and stored after delivery for later use by the infant, a matched sibling, or an unrelated patient.

Bone marrow transplantation is a widely accepted and successful therapy for treating a variety of malignant and nonmalignant diseases. Continuing research should yield new methods to ensure successful engraftment and to prevent or reduce complications post-BMT. Many patients with cancer have been cured with BMT. However, much work remains to improve survival and to better manage complications. New approaches under investigation may expand the availability of transplantation and improve short- and long-term survival and quality of life.

The world's first successful bone marrow transplant (BMT) was performed at the University of Minnesota in 1968 under the direction of Robert Good, M.D., using marrow from a related donor to replace the immune system of an infant born with severe combined immune deficiency. Since then, the number of BMTs performed each year has increased to more than 20,000 worldwide (see Figure 1, page 24). Today, a growing range of therapies and techniques has enabled bone marrow transplant physicians to offer hope to patients with hematologic malignancies and to extend transplant therapy to solid tumors, such as breast cancer, as well as certain inherited diseases, such as Fanconi anemia and Hurler syndrome. (Table 1 lists factors affecting BMT success.)

In 1968, a related donor was the only source available to provide stem cells for rebuilding a patient's immune system following high-dose chemotherapy and radiation. Today, researchers are investigating alternative stem cell sources to make therapy available to more patients, and physicians are performing transplants using stem cells obtained from related and unrelated allogeneic donors. Stem cells are obtained from bone marrow, peripheral blood, and, most recently, umbilical cord blood. Umbilical cord blood can be stored after birth, if the parents choose, and used for transplantation later either by the infant, a matched sibling, or an unrelated patient.¹ Researchers also are investigating autologous transplants using patients' own bone marrow or peripheral blood (see Figures 2 and 3).

UNRELATED DONOR MARROW TRANSPLANTATION

As many as 75% of potential bone

marrow transplant candidates lack a suitably matched sibling who can be a donor. To overcome this problem, marrow from unrelated donors is being used more frequently and with rapidly improving outcomes. The first marrow transplant from an unrelated donor was performed in 1979. By 1985, researchers had determined that unrelated donor transplantation was a promising option, and they sought to establish a volunteer donor registry. The National Marrow Donor Program, based in Minneapolis, was established in 1986, and today it manages a registry that includes 2 million potential donors worldwide.

Large registries of potential donors are needed because close tissue matching is required in transplants with an unrelated donor. Patients are typed for six cell surface proteins, HLA-A, B, and DR, each of which is highly polymorphic in the population. At least five of the six proteins

Table 1

Factors influencing BMT success

Success of bone marrow transplantation depends on many steps and requires supportive treatment extending over several months. Key factors affecting the success of BMT include:

- matched donor availability (preferred match is at least five of six HLA antigens);
- successful engraftment;
- occurrence and severity of graft-versus-host-disease (GVHD);
- risk of disease relapse;
- risk of infection; and
- treatment complications.

ANNUAL NUMBER OF TRANSPLANTS WORLDWIDE 1970-1994

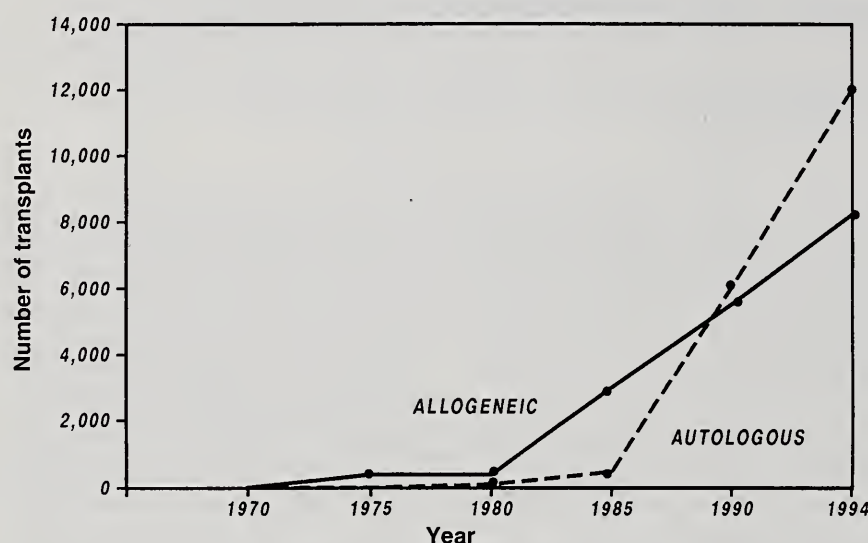


Figure 1—The data presented here, as well as in Figures 2 and 3, were obtained from the Statistical Center of the International Bone Marrow Transplant Registry and the Autologous Blood and Marrow Transplant Registry—North America. The analysis has not been reviewed or approved by the advisory committees of the IBMTR and ABMTR.

DONOR TYPE FOR ALLOTRANSPLANTS

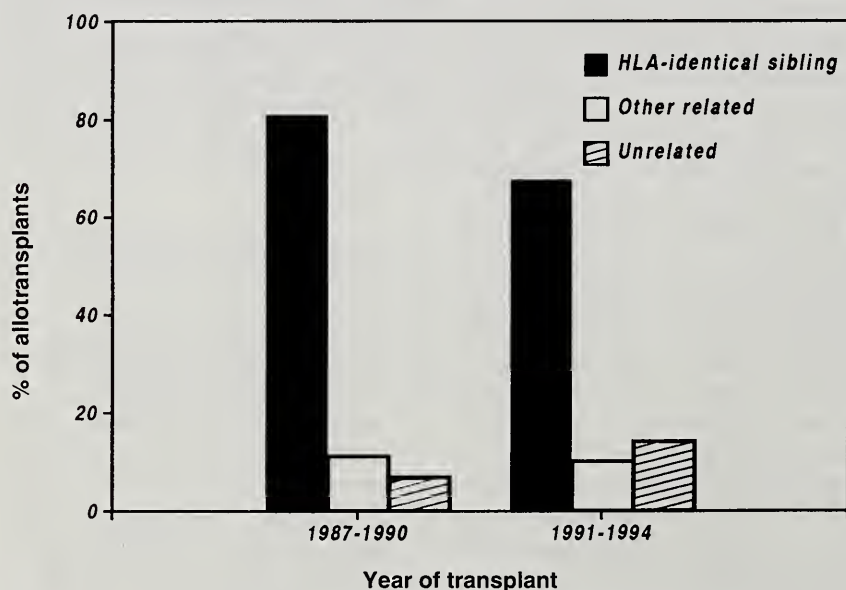


Figure 2

must be matched. The probability of finding another individual with the same HLA type can be as low as one in a million for rare tissue types.

More than 400 patients have received an unrelated donor BMT at

the University of Minnesota to date (see Figure 4). Stella Davies, M.D., director of the university's unrelated donor transplant program, studied the first 211 unrelated donor transplants performed at the university

between 1985 and 1992.² This study showed that unrelated donor transplantation can be a good alternative to related donor transplantation in many circumstances:

- Patients undergoing transplants using fully matched (six out of six antigens) unrelated donors have survival rates similar to patients undergoing transplants using HLA-matched sibling donors.

- Use of unrelated donor marrow is associated with a lower relapse rate than use of sibling marrow, probably because of an increased graft-versus-leukemia effect in unrelated donor transplant recipients.

- In patients under age 18, survival after a fully matched (six of six antigens) unrelated donor transplant is not significantly different from unrelated donor transplant with a major mismatch at a single HLA A or B locus (five of six antigens).

- For patients over age 18, five of six antigen-matched unrelated donor transplants show significantly worse results than six of six antigen-matched unrelated donor transplants. In hopes of improving these results, physicians are using better methods of graft-versus-host disease (GVHD) prophylaxis, such as T-cell depletion of the donor marrow graft. Investigators are evaluating the true benefit of T-cell depletion in a phase II randomized clinical trial.

In addition to medical outcomes, quality of life following transplantation is an important consideration in comparing treatment options. Davies assessed the quality of life for patients successfully treated with related and unrelated donor transplantation. She evaluated physical and social function, daily activities, general health, and return to work or school. She found that long-term survivors (greater than two years) of both related and unrelated transplants can expect a normal or near normal quality of life in the majority of cases.²

UMBILICAL CORD BLOOD TRANSPLANTATION

Umbilical cord blood (UCB) offers another source of stem cells. In addition to precluding the need to find a donor and eliminating the inherent

delay involved in a marrow donor search, using UCB avoids the risk, inconvenience, and expense of allogeneic donor bone marrow harvest.

Umbilical cord blood is a rich source of hematopoietic precursors and is routinely discarded. UCB can easily be collected from the placenta and umbilical cord after delivery, then frozen for use in transplantation at no risk to the mother or child. Collection of sibling cord blood should always be considered for children with hematologic or metabolic disorders. The odds of a transplant candidate obtaining closely matched UCB from a sibling are 25% if the mother happens to be pregnant.

To date, approximately 150 cord blood transplants have been performed worldwide, and more than 70% of those patients are living. John Wagner, M.D., performed the world's first cord blood transplant for leukemia in 1990.³ Wagner has performed five related and 13 unrelated cord blood transplants at the University of Minnesota. The great majority of cord blood transplants so far have involved children, but the potential efficacy of UCB transplantation in adults is now being explored. More than 100 UCB transplants from *unrelated* donors have been performed. Not only has the incidence of engraftment been high, but the risk of severe GVHD appears to be low, suggesting that HLA matching may be "less strict" with UCB as compared with bone marrow. Other advantages of UCB are immediate availability and low rates of viral contamination. Together, these attributes make UCB an attractive alternative to unrelated donor bone marrow.

Although the potential advantages of UCB transplants are significant, the number of frozen units of unrelated donor UCB available is still quite small—existing cord blood banks in the United States currently store about 6,000 units. Cord blood banks, being developed worldwide, have the potential to collect rare tissue types, including units representing all ethnic and racial groups. When patients are referred to the University of Minnesota for unrelated donor transplantation, searches of both bone mar-

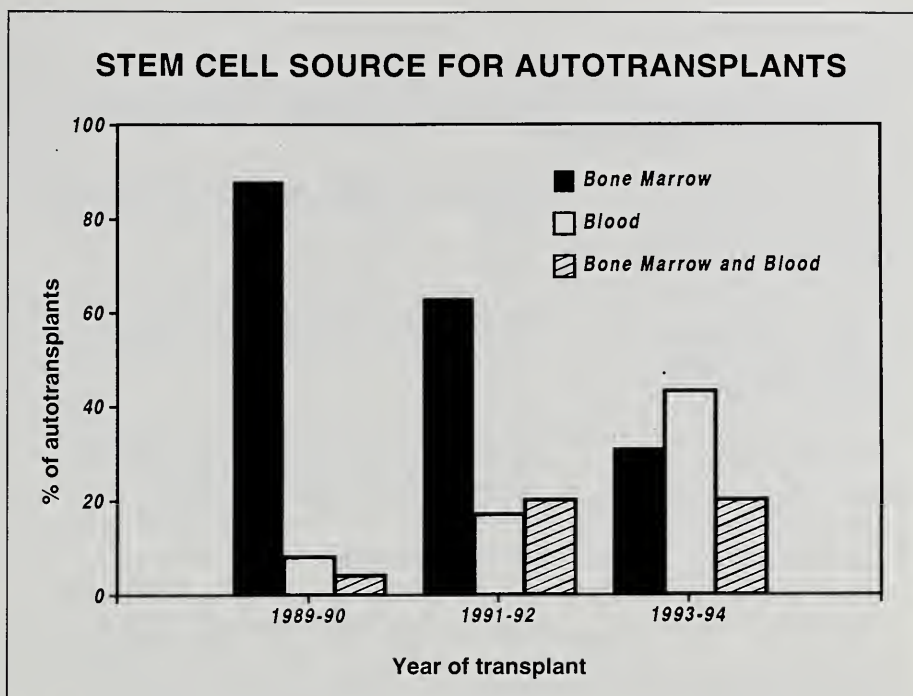


Figure 3

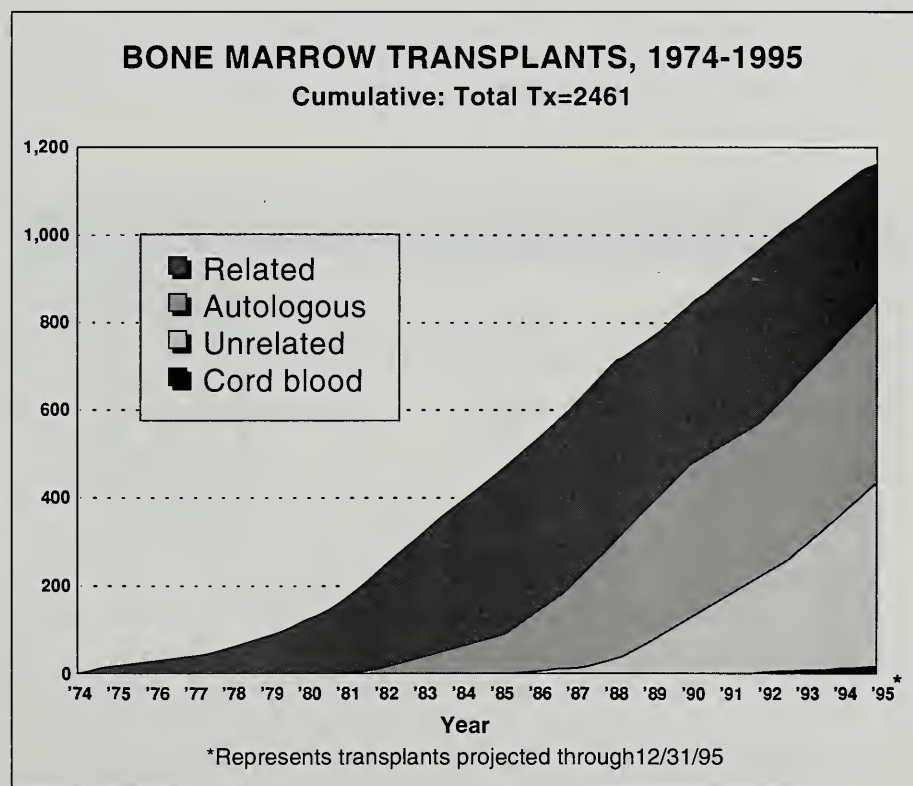


Figure 4—Source: Bone Marrow Transplant Program Database, U of M.

row and cord blood registries are performed. Depending on the patient's disease and disease status, UCB may be preferable to marrow, if it's been collected. The major benefit is its immediate availability; earlier transplantation may improve outcome.

AUTOLOGOUS TRANSPLANTATION

Autologous bone marrow transplantation (ABMT) has been successfully used to treat cancers that do not involve the bone marrow, such as

Table 2

Areas of special interest—University of Minnesota Bone Marrow Transplant Program faculty

Philip B. McGlave, M.D., director, Adult Bone Marrow Transplantation	Biology and transplantation of human stem cells in CML
Norma K.C. Ramsay, M.D., director, Pediatric Bone Marrow Transplantation	BMT for childhood leukemia and solid tumors
Bruce Blazar, M.D.	Murine (mouse) models of graft rejection, graft- versus-host disease, and BMT biology
Linda Burns, M.D.	BMT for breast cancer
Stella Davies, M.B.B.S., Ph.D.	Unrelated donor bone marrow transplantation
Helen Enright, M.D.	Prophylaxis and treatment of chronic graft- versus-host disease
Alexandra Filipovich, M.D.	Immune deficiency disorders
Emmanuel Katsanis, M.D.	BMT for neuroblastoma
John Kersey, M.D.	Leukemia biology
William Krivit, M.D., Ph.D.	Inherited metabolic disorders
Jeffrey Miller, M.D.	Post-transplant immunotherapy for prevention of CML and breast cancer relapse
Wesley Miller, M.D.	Prophylaxis and treatment of cytomegalovirus (CMV)
Paul Orchard, M.D.	BMT for pediatric hematologic diseases
Arne Slungaard, M.D.	BMT for autoimmune diseases
Fatih Uckun, M.D., Ph.D.	Immunotherapy for prevention of leukemia relapse
Catherine Verfaillie, M.D.	Stem cell selection, ex vivo cultivation, and gene therapy in both normal and leukemic bone marrow
John Wagner, M.D.	Umbilical cord blood as a source of stem cells for transplantation
Daniel Weisdorf, M.D.	Autologous BMT for lymphoma and multiple myeloma

certain lymphomas and breast cancer. In addition, autologous transplantation eliminates the problem of donor availability when a suitable allogeneic donor cannot be found. This is an especially critical factor for patients with rapidly progressive cancers and patients in whom remissions are likely to be short.

Advanced cell sorting techniques are now making it possible to separate healthy stem cells from cancer cells. This allows patients with diseases such as chronic myelogenous leukemia (CML) who have malignant cells in the bone marrow to be candidates for autologous transplantation. Autologous bone marrow transplantation for CML has to date not been curative, but it can extend survival. It provides a treatment option for patients with CML who lack a matched related or unrelated donor or who are too old to be candidates for allogeneic transplant (it is typically not offered to patients over age 55 with either a related or unrelated donor). Use of autologous transplantation for CML is an exciting advance because reduced toxicities allow it to be used in older patients who could not tolerate allogeneic transplantation.

A multicenter study of 200 patients with CML who received ABMT showed that autologous transplants result in a plateau in the survival curve not observed in conventional treatments. Autologous transplants are associated with a high engraftment rate, low mortality, and prompt return of both younger and older patients to normal activity levels.⁴

The University of Minnesota and other research institutions are pursuing new, potentially curative ABMT techniques for CML. The goal of ABMT for patients with CML is to separate healthy hematopoietic stem cells from the leukemia cells that have the Philadelphia chromosome (Ph) and the BCR/ABL gene rearrangement. Under the direction of Catherine Verfaillie, M.D., at the University of Minnesota, a protocol has been approved by the FDA for using fluorescence-activated cell sorting (FACS) to separate benign stem cells from leukemia cells.⁵ Transplantation with these stem cells may re-

store normal hematopoiesis and be curative. (See Table 2 for a list of the university's Bone Marrow Transplant Program faculty and their areas of interest.)

While allogeneic transplant has been the treatment of choice for patients with malignancies that involve the marrow, such as leukemia, transplantation using autologous bone marrow or peripheral blood stem cells has been widely used for other diseases, such as breast cancer. Recurrence of cancer following transplantation remains a significant problem, however, despite the initial promise autologous transplant offers in the treatment of breast cancer. More than 60% of these patients have shown clinical response to the high-dose chemotherapy used in ABMT, but results both from Minnesota and nationally demonstrate that only 20% to 25% of patients have prolonged disease-free survival.^{6,7} Unfortunately, the majority will relapse within two years of treatment. This suggests that high-dose

chemotherapy and radiation therapy alone are inadequate to eradicate aggressive disease in many patients. Researchers are developing new therapeutic strategies, such as immunotherapy, to eliminate residual chemotherapy-resistant tumor cells.⁸

One form of immunotherapy, which University of Minnesota researchers Linda Burns, M.D., and Jeffrey Miller, M.D., are studying, involves giving patients the immunotherapeutic cytokine interleukin-2 (IL-2) post-transplant. IL-2 activates Natural Killer (NK) cells in the patient's own immune system to help destroy remaining cancer cells. This study takes advantage of the increased number of NK cells present post-transplant in a minimal residual disease state to enhance the patient's own antitumor immune response.^{9,10}

RELATED DONOR BMT

When patients with acute leukemia require BMT, marrow from an HLA-identical sibling donor remains the best option when it's available.

Research is focusing on ways to improve long-term survival using targeted biotherapeutic agents to reduce post-transplant leukemia relapse. Fatih Uckun, M.D., Ph.D., of the University of Minnesota is investigating an example of this novel approach to treatment. This therapy uses a plant-derived toxin (pokeweed antiviral protein, or PAP), which is linked to a monoclonal antibody (B43) that recognizes receptors (CD19) on the surface of all acute lymphoblastic leukemia cells.¹¹ Uckun has developed a number of these compounds and is testing them in both bone marrow transplant patients and other patients with acute leukemia to reduce relapse.

CONCLUSION

Although bone marrow transplantation was seldom performed as recently as 15 years ago, it has since become widely accepted as a successful treatment for a number of malignant and nonmalignant diseases. Outcomes have improved, but only

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further investigation will increase success. **MM**

Norma Ramsay is a professor of pediatrics and director of Pediatric Bone Marrow Transplantation at the University of Minnesota. Stella Davies is an assistant professor of pediatrics, and John Wagner is an associate professor of pediatrics at the University of Minnesota. Elizabeth McGough is administrative director of the Bone Marrow Transplant Program at the University of Minnesota Health System. Philip McGlave is a professor of medicine and director of Adult Bone Marrow Transplantation at the University of Minnesota.

REFERENCES

1. Wagner JE, Kernan NA, Steinbuch M, Broxmeyer HE, Gluckman E. Allogeneic sibling umbilical cord blood transplantation in forty-four children with malignant and non-malignant disease. *Lancet* 1995; 346:214-9.
2. Davies SM, Shu XO, Blazar BR, et al. Unrelated donor bone marrow transplantation: influence of HLA A and B incompatibility on outcome. *Blood* 1995;86:1636-42.
3. Wagner JE, Broxmeyer HE, Byrd RL, et al. Use of umbilical cord and placental blood after myeloablative therapy for juvenile chronic myelogenous leukemia: analysis of engraftment. *Blood* 1992; 79:1874-81.
4. McGlave PB, DeFabritiis P, Deisseroth A, et al. Autologous transplants for chronic myelogenous leukaemia: results from eight transplant groups. *Lancet* 1994;343: 1486-8.
5. Verfaillie CM, Bhatia R, Miller W, et al. Benign primitive progenitors can be selected on the basis of the CD34+/HLA-DR- phenotype in early chronic phase but not advanced phase CML. *Blood*, to be published.
6. Shpall EJ, Jones RB, Bearman SI, et al. Transplantation of enriched CD34-positive autologous marrow into breast cancer patients following high-dose chemotherapy: influence of CD34-positive peripheral-blood progenitors and growth factors on engraftment. *J Clin Oncol* 1994;12:28-36.
7. Antman K, Ayash L, Elias A, et al. A phase II study of high-dose cyclophosphamide, thiopeta, and carboplatin with autologous marrow support in women with measurable advanced breast cancer responding to standard-dose therapy. *J Clin Oncol* 1991;10:102-10.
8. Meeham KR, Rajagopal C, Verma UN, et al. Biologic and clinical correlates of interleukin-2 (IL-2) administration in peripheral blood stem cell (PBSC) transplantation for breast cancer. *Blood* 1995; 86:387a.
9. Miller JS, Klingsporn SO, Lund J, Perry EH, Verfaillie CM, McGlave PB. Large scale ex vivo expansion and activation of human natural killer cells for autologous therapy. *Bone Marrow Transplant* 1994; 14:555-62.
10. Miller JS, Verfaillie C, McGlave PB. Expansion and activation of human natural killer cells for autologous therapy. *J Hematother* 1994;3:71-4.
11. Waddick KG, Gunther R, Chelstrom LM, et al. In vitro and in vivo anti-leukemic activity of B43 (anti-CD19)-pokeweed antiviral protein immunotoxin against radiation resistant human pre-B acute lymphoblastic leukemia cells. *Blood* 1995;86:4228-33.



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Genetic Testing for Familial Cancer

A Clinician's Perspective

Joanne M. Hilden, M.D., Jan Watterson, B.A., and Cynthia L. Garr, M.D.

ABSTRACT

Molecular genetics researchers have recently identified several genes (and mutations) that result in family cancers. This has prompted the development of molecular diagnostic tests to identify individuals at risk, making it possible to prevent certain types of cancer. However, detection and prevention of certain malignancies are impeded because few medical practitioners know of these tests, and because patients fear the emotional consequences of testing.

To highlight some of these issues, we describe a patient who chose to be tested for the RET gene mutation. The mutation was identified, additional family members were tested, and several were found to be at risk. The RET gene mutation is 100% predictive for the ultimate development of medullary thyroid cancer. Testing and counseling provided this patient and her family with information not only about the thyroid cancer in their family, but also about multiple endocrine neoplasia, a syndrome resulting from mutation of this particular gene.

Familial cancer clinics are being established to assist patients and physicians who face questions about familial diseases and the value of genetic testing. We include in this report information about the familial cancer clinics in Minnesota and list the services and testing opportunities available at these clinics.

Recent progress in molecular genetic diagnostic research has led to the development of tests to predict future disease. These scientific advances have received abundant media attention in both the medical literature and the lay press. However, the absolute risk of developing a particular cancer, even if a molecular gene defect is present, is still under study. The question for each individual considering being tested is, "Can anything be done to prevent the development of familial disease?"

Individuals at risk for familial disease have strong, conflicting emotions when faced with the opportunity to undergo genetic testing, as evidenced by the well-publicized Huntington disease cases.^{1,2} Physicians and other family members also face difficult decisions. Who should be tested? Will health insurance plans cover such testing, particularly for extended families? Who is responsible for educating the extended family? Should children be tested? How will the emotional well-being of those who choose testing be affected?

Medical practitioners today are likely to encounter patients who will ask about familial cancer. Patients may question their risk for developing one of the more common cancers, such as breast or colon cancer, or their children's risk for developing a cancer that has been observed in the family. Or they may ask for information about available tests reported in the news media. Because the field of molecular genetic testing is advancing so rapidly, it is difficult for practitioners to keep abreast of new developments.

In an illustrative case, a mother asked a physician if her two children should be screened for medullary thyroid carcinoma (MTC), for which

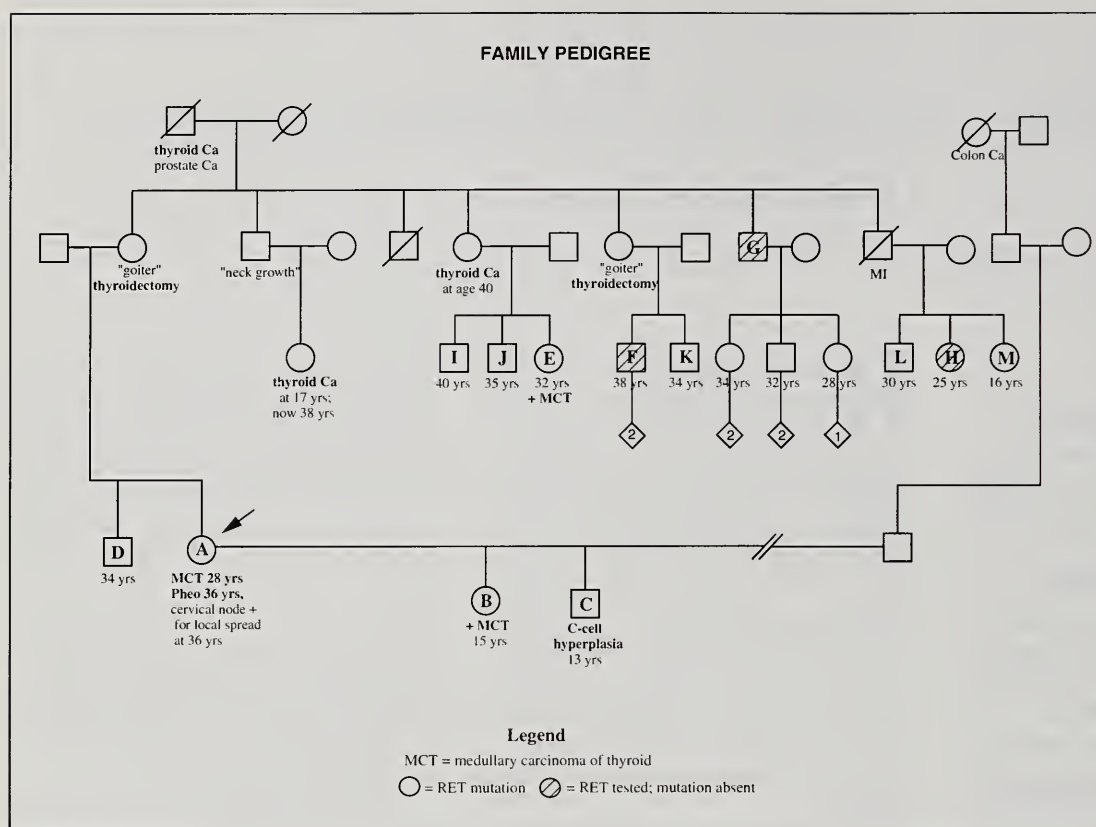
she had been treated. Eighty percent of MTC cases arise sporadically; the remaining 20% of patients inherit MTC in an autosomal dominant fashion, either as familial MTC or as part of multiple endocrine neoplasia (MEN).³ MEN is subdivided into type 2A (which includes MTC, pheochromocytoma, and hyperparathyroidism)⁴ and type 2B (which includes MTC, pheochromocytoma, marfanoid habitus, and ganglioglioma phenotype, but with normal parathyroid glands).⁵

The malignant cells in MTC arise from the thyroid C-cells that secrete calcitonin; the best MTC screening test available in the past measured basal or pentagastrin-stimulated calcitonin levels.⁶ Abnormal levels indicated the presence of premalignant C-cell hyperplasia or outright cancer. MTC screening was necessary for any family member of an MTC patient, starting at about age 5 and annually thereafter. Individuals with abnormal results were encouraged to proceed with thyroidectomy because the prognosis for MTC patients was vastly improved with early surgery.^{5,7} However, the test was plagued with false negative results,⁶ and compliance was poor for annual testing.

A molecular diagnostic test is now available that can determine if a mutation in the RET proto-oncogene on chromosome 10 is present; it is 100% predictive for the eventual development of MTC.⁸⁻¹⁰ If a mutation is detected, thyroidectomy is recommended as a truly preventive measure,¹¹ and monitoring for the full MEN2 syndrome should commence. If no mutation is detected, annual testing is no longer necessary for that patient or that patient's children.

CASE STUDY

A 28-year-old woman (Patient A)



Figure—The kindred diagram developed for the family of Patient A shows many “thyroid patients.”

developed MTC but had no clinical signs of pheochromocytoma, hyperparathyroidism, or ganglioneuromas. Her two children had normal basal calcitonin levels when tested at ages 4 and 6. Eight years later, at the prompting of her daughter, the woman asked if her children should again be tested. A kindred diagram (see figure) was developed, which showed many “thyroid patients.” There was no evidence of MEN in any family member, but the index of suspicion for familial MTC was high. Because molecular diagnostic testing had now become available, Patient A agreed to undergo testing to learn more about the risks her children might face. Results yielded one of the classic RET gene mutations, which indicated the need to test for that specific mutation in her children. Testing showed the children had the same RET gene mutation. Both children underwent thyroidectomies; one (Patient B) had localized MTC, and the other (Patient C) had premalignant C-cell hyperplasia. Thus, thyroidectomy prevented the development of cancer in this second child.

Current molecular testing cannot yet determine whether MTC alone or the entire MEN syndrome will develop in a patient;¹⁰ surveillance for pheochromocytoma and hyperparathyroidism continues to be necessary. Further testing of Patient A revealed she had previously undetected pheochromocytoma. This established the diagnosis of MEN, type 2A; she had no signs of hyperparathyroidism.

The results of the molecular genetic testing, although disheartening, were extremely useful for this family. Cancer was prevented in one child and was detected in the other before it spread. MEN syndrome was diagnosed, and Patient A subsequently was treated for pheochromocytoma before it became clinically significant. She and her children are being monitored for hyperparathyroidism; her children also will be observed for pheochromocytoma.

The extended family was contacted and educated about this disorder. Patients D and E chose to be tested and were found to have the gene mutation. Patient D is currently

under evaluation, and Patient E underwent thyroidectomy, which showed localized MTC. Individuals F, G, and H were tested and did not have the gene mutation; no testing is therefore necessary for their children. Patients I through M remain untested at this time, by personal or parental preference (the mother of Patient M declines testing for her daughter).

DISCUSSION

Familial cancer clinics recently have been established to assist patients with concerns about their genetic susceptibility to malignancies.

A recent national survey reported that most of these clinics offer medical evaluation, cancer risk assessment, genetic counseling, pedigree analysis, and molecular diagnostic testing.¹² Although families and individuals are now being referred to these clinics, many individuals still do not wish to undergo testing. At a recent American Society of Clinical Oncology meeting, for instance, it was reported that members of Li-Fraumeni syndrome families (in which p53 mutations portend a 50% chance of developing certain types of cancer by age 30)¹³ are quite often reluctant to receive genetic counseling and testing.¹⁴ Some reasons cited for not participating were anxiety about uninsurability, concern about emotional upset, and disbelief in the inherited nature of cancer and the value of testing in the prevention of cancer. Those who did participate in genetic counseling and testing said they were motivated by a desire to know their risks, to prevent cancer from developing, and to fully understand the risks for their children.

In more publicized accounts of

individuals struggling with the decision to undergo genetic testing, reactions have been similar. The *New York Times Magazine* ran a detailed account of one man's decision to forego testing for a gene mutation, which in his family indicates the development of fatal hypertrophic cardiomyopathy.¹⁵ He cited his desire to retain the "privilege of hope." In contrast, a prominent Minnesota newscaster recently described a decision to undergo testing for colon cancer risk. Testing and genetic counseling gave a better understanding of personal risk and provided education about monitoring techniques for colon and other cancers. Although the broadcaster found the testing to be useful, this individual emphasized that not all family members chose to be tested.

Physicians will likely encounter a similar range of reactions when offering their patients genetic screening tests. Although physicians may be as ambivalent as their patients about the benefit of these tests, it is clearly their responsibility to ensure that each patient is well informed and able to make an educated decision. Patients' immediate and extended families should also be educated and informed about available tests. Testing can often identify ways in which families can protect their health. It may also ease uncertainty for individuals who have strong family histories of certain diseases.^{16,17}

And although the opportunity to prevent cancer is rare, in the case of RET gene mutations, it is quite possible. Children will often provide the impetus for testing, as was the case with our Patient A. However, physicians must respect their patients' decisions not to be tested, even if they strongly believe testing should be undertaken.

Rapid advances in the field of hereditary cancer testing make it difficult to counsel patients adequately. Many molecular genetic tests are now available (particularly for hereditary predisposition to colon cancer and breast cancer), but because most have limited predictive value (unlike RET gene testing), their use requires approved research protocols. Patients who ask to be tested must understand and approve of their participa-

Table <i>Familial cancer services in Minnesota</i>	
Institution	Services offered
University of Minnesota Familial Cancer Clinic, Minneapolis 612/625-7419	Comprehensive program, including a multidisciplinary team offering family health history interviews, genetic counseling, family support and education, appropriate medical and genetic tests, and recommendations about future health issues. Research is a key component of the program.
Mayo Clinic Familial Cancer Program, Rochester 507/284-4300	Comprehensive program, including a multidisciplinary team offering family health history interviews, genetic counseling, family support and education, appropriate medical and genetic tests, and recommendations about future health issues. Research is a key component of the program.
United Center for Breast Care, St. Paul 612/220-8300	Family health history interviews, genetic counseling, family support and education, referrals for genetic testing, and recommendations about future health issues.
Virginia Piper Cancer Institute of Abbott Northwestern Hospital, Minneapolis 612/863-8651	Family health history interviews, genetic counseling, family support and education, genetic testing, and recommendations about future health issues.
Many other institutions in the state offer genetic counseling and referrals to one of the comprehensive familial cancer programs listed above.	

tion in such research. Many patients will be willing to participate and will appreciate the opportunity to contribute to medical research, but others will balk at the thought of being a "guinea pig." Other patients will have financial concerns because third-party payers may refuse to cover the cost of testing (as was the case for our Patient A, even though testing prevented cancer in her child). There is also a concern that payers will discriminate against known mutation carriers, as identified by testing. Ethical questions will be raised when patients ask to be tested, when others in the family do not want to participate, or when the issue of contacting members of an extended family is discussed. Pre- and post-test counsel-

ing is essential for many tests, particularly those with good predictive value for disease or fatal malignancy. When a genetic defect is not 100% predictive of disease, counseling is done in the context of family history/pedigree and involves education about screening tests, risk-factor avoidance (such as smoking), and self-exams.

Many physicians do not have the resources to devote to patients who have hereditary cancer concerns and questions about whether to undergo genetic testing. Familial cancer clinics (see the table) are a valuable resource for both patients and physicians contemplating these difficult decisions. The health professionals in these clinics face the challenge of

providing extensive services to those at risk for developing familial cancers, as well as educating the community about this complex and rapidly changing field of research. **MM**

ACKNOWLEDGMENT

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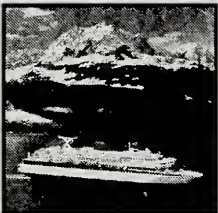
Joanne Hilden is a pediatric oncologist and Jan Watterson is a research assistant in the Department of Hematology/Oncology at Children's Health Care—St. Paul. Cynthia Garr is a primary care pediatrician at Pediatric and Adolescent Health in St. Paul.

REFERENCES

1. Kessler S, Field T, Worth L, Mosbarger H. Attitude of persons at risk for Huntington disease toward predictive testing. *Am J Med Genet* 1987;26:259-70.
2. Brandt J, Quaid KA, Folstein SE, et al. Presymptomatic diagnosis of delayed-onset disease with linked DNA markers. The experience in Huntington's disease. *JAMA* 1989;261:3108-14.
3. Murray D. The thyroid gland. In: Kovacs K, Asa S, eds. *Functional endocrine pathology*. Boston: Blackwell Scientific Publishers, 1991:338.
4. Steiner AL, Goodman AD, Powers SR. Study of a kindred with pheochromocytoma, medullary thyroid carcinoma, hyperparathyroidism and Cushing's disease: multiple endocrine neoplasia type II. *Medicine* 1968;47:371-409.
5. Telander RL, Zimmerman D, van Heerden JA, Sizemore GW. Results of early thyroidectomy for medullary thyroid carcinoma in children with multiple endocrine neoplasia type 2. *J Pediatr Surg* 1986;21:1190-4.
6. Sizemore GW, Go VLW. Stimulation tests for diagnosis of medullary thyroid carcinoma. *Mayo Clin Proc* 1975;50:53-6.
7. Telander RL, Zimmerman D, Sizemore GW, van Heerden JA, Grant CS. Medullary carcinoma in children. Results of early detection and surgery. *Arch Surg* 1989;124:841-3.
8. Donis-Keller H, Dou S, Chi D, et al. Mutations in the RET proto-oncogene are associated with MEN 2A and FMCT. *Hum Mol Genet* 1993;2:851-6.
9. Lips CJM, Landsvater RM, Höppener JWM, et al. Clinical screening as compared with DNA analysis in families with multiple endocrine neoplasia type 2A. *N Engl J Med* 1994;331:828-35.
10. Mulligan LM, Eng C, Healey CS, et al. Specific mutations of the RET proto-oncogene are related to disease phenotype in MEN 2A and FMTC. *Nature Genetics* 1994;6:70-4.
11. Utiger RD. Medullary thyroid carcinoma, genes, and the prevention of cancer. *N Engl J Med* 1994;331:870-1.
12. Thompson JA, Wiesner GL, Sellers TA, et al. Genetic services for familial cancer patients: a survey of national Cancer Institute Cancer Centers. *J Natl Cancer Inst* 1995;87:1446-55.
13. Malkin D. The Li-Fraumeni syndrome. Principles & Practice of. *Oncology (PPO Updates)* 1993;7:1-14.
14. Patenaude AF, Schneider KA, Gonsoulin J, et al. Acceptance of a predisposition testing program for germline p53 alterations by members of Li-Fraumeni cancer syndrome families [Abstract 1644]. *Proceedings of ASCO* 1995;14:502.
15. Siebert C. Living with toxic knowledge. *New York Times Magazine* 1995 September;17:50-7.
16. Wiggins S, Whyte P, Huggins M, et al. The psychological consequences of predictive testing for Huntington's disease. *N Engl J Med* 1992;327:1401-5.
17. Hayes CV. Genetic testing for Huntington's disease—a family issue. *N Engl J Med* 1992;327:1449-51.

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ANNOUNCEMENTS

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MMA OFFERS PAYERS PERSPECTIVE WORKSHOPS

The Minnesota Medical Association announces its 1996 Payers Perspective Workshops. The workshops will be held from 9 a.m. to 3:30 p.m. on the following dates:

Tuesday, April 16—St. Paul
Thursday, April 18—St. Paul
Tuesday, April 23—Duluth
Thursday, April 25—St. Cloud

The registration fee is \$90 for each registrant. For more information, call Vicki Westling at the MMA, 612/378-1875 or 800/999-1875.

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FIREARM SAFETY BROCHURE, 'UNLOAD IT & LOCK IT,' IS AVAILABLE FROM MMA

The Minnesota Medical Association has developed the brochure, "Unload It and Lock It," which includes a firearm safety checklist for physicians and strongly urges people to unload and lock their stored firearms. The MMA brochure was funded by Allina Health System, Blue Cross Blue Shield of Minnesota, and HealthPartners, and it was endorsed by Attorney General Hubert H. Humphrey III, the Department of Natural Resources, the Minnesota Medical Association, and the MMA Alliance. To obtain brochures for your patients, call Beth Hoheisel at 612/378-1875 or 800/999-1875. The brochure can also be used as a poster in your waiting room.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

Senate Passes Youth Access to Firearms Bill

In a victory for the MMA, the Youth Access to Firearms bill passed the Senate on a 38-25 vote March 13. This bill raises the age from under 14 to under 18 when "reasonable action" is required to prevent children from gaining access to stored firearms. A similar bill passed the House as part of the Omnibus Crime bill.

Despite vigorous MMA lobbying, the provision that would have defined "reasonable action" as unloading and locking a firearm and storing the ammunition separately was removed by an amendment offered on the Senate floor by Sen. Gene Merriam, DFL-Coon Rapids. Urging the Senate to defeat Merriam's amendment, the bill's author, Sen. Jane Ranum, DFL-Minneapolis, said the negligent storage provision was needed to clarify the law so prosecutors would know if someone had taken reasonable action and to set the standard of conduct for parents to follow. "When I grew up on a Minnesota farm, we didn't have as many teenagers committing suicide as we do now. It is time to revisit what is 'reasonable,'" Ranum said. One study found that 91 percent of suicide attempts with guns were successful, compared with 23 percent with poison and 4 percent with knives.

The amendment stripping off the unload-and-lock provision was adopted on a 42-20 vote, however, after Sen. Warren Limmer, R-Maple

Grove, told the Senate that rural Minnesota families need to have a loaded gun handy to protect their children from such dangers as rabid raccoons. In response, Sen. John Hottinger, DFL-Mankato, said, "I don't know how many Minnesota children died from rabid raccoon attacks last year, but I do know that 62 children died unnecessarily from unintentional shootings and firearm suicides. I suspect there were 62 fewer raccoon-related deaths."

Even without the clarification of "reasonable action," Senate passage of the Youth Access to Firearms bill is a major accomplishment. Three-fourths of the gun deaths among Minnesota children occur in the 15 to 18 age range. Urging passage of the bill, Sen. Ellen Anderson, DFL-St. Paul, told the Senate how impressed she had been by the young people who came forward to testify before the Senate Crime Prevention Committee (see the March issue of *The Monitor*). "We should pay more attention to teenagers who know the dangers they face," Anderson said. "The teenage years are a time for tempting fate."

Ranum was pleased with the passage of her bill, which will be folded into the Senate Omnibus Crime bill. "Do I wish the entire bill passed? Sure I do," Ranum said. "But this is a significant victory. Anytime you want to accomplish anything, you have to take it step by step."

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Viewpoint

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Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

Break the Gridlock in Washington

A few years ago, there was widespread concern about the fact that 37 million Americans were uninsured. Now the number of uninsured has climbed to 40 million but concern has mysteriously faded, at least in Washington.

In Minnesota, we have worked hard to hold down the number of uninsured and to improve health care access. Insurance reforms have made coverage more accessible, and the MinnesotaCare program has kept thousands of people off the welfare rolls while providing them with affordable health care. The rate of uninsured in Minnesota has held steady at 9 percent since 1990 while the national rate has risen to 15 percent.

To accomplish this, Minnesota physicians have been asked to make enormous sacrifices to provide care for those who are unable to pay. We were hit with the \$400 surcharge and the 2 percent tax on health care services to help pay for MinnesotaCare. We are providing the comprehensive benefits in the Medical Assistance program at reimbursement rates that are considerably less than the going rate. At the same time, we suffer from Minnesota's low Medicare reimbursement rate and the inability to balance bill. Much of the success of Minnesota's efforts to help the needy and the uninsured is due to sacrifices made by the medical com-

munity.

But while Minnesota has moved forward in improving access to health care, the nation has been at a standstill. Congress has failed to enact even the most basic insurance reforms. Insurance companies are still allowed to deny coverage on the basis of preexisting conditions, and people are afraid to change jobs because they fear the loss of insurance coverage. Fortunately, there may be some progress soon. The bipartisan Kennedy/Kassebaum bill, which has been endorsed by the American Medical Association, is expected to come up for a vote between April 15 and May 3 (see page 37). This will begin to make insurance more accessible, although not necessarily more affordable.

In addition, there may finally be progress on breaking the deadlock over the Medicaid portion of the federal budget bill. The National Governors' Association proposal has brought negotiators back to the table (see facing page). This compromise between the Republican block grant proposal and the Democratic goal of maintaining Medicaid as an entitlement has stimulated discussion, but opponents have found fault with a number of its recommendations.

The governors' plan would require states to provide benefits for pregnant women and children, but it would allow the states to define who

is disabled and to decide the amount, scope, and duration of benefits. The plan has drawn fire from AIDS and mental health advocacy groups, which fear loss of benefits. In addition, the Children's Defense Fund has warned that the governors' plan would eliminate guaranteed coverage for 4.9 million children and 5.5 million parents, including 3.1 million children in working poor households and 1.6 million children whose parents are on welfare.

Minnesota has a lot at stake in the Medicaid debate. If the federal government washes its hands of any responsibility for setting a national floor for Medicaid benefits and eligibility, Minnesota is likely to become a magnet for the sick and needy of America. There are rumors that the disabled are already moving to Minnesota because of our state's comprehensive Medical Assistance benefits. We should not be penalized for leading the nation toward improved access to health care coverage.

The debate over the Medicare portion of the budget also raises concerns. Currently, Minnesota seniors continue to receive far leaner Medicare benefits than seniors in other parts of the country. Recently, I heard that in certain East Coast cities Medicare HMO patients are picked up by limousines and offered extensive benefits, including eye glasses and prescription drugs. HMOs in some states are able to offer these rich benefits packages because their Medicare capitation rate is so high. The capitation rate is as low as \$228 per enrollee in some Minnesota counties, compared with \$681 in Philadelphia. Geographic variations in Medicare reimbursement—for both fee-for-service and capitated systems—should be based on true practice costs, not on county-level historic Medicare costs.

We recognize the need to balance the federal budget and reduce the national deficit, but the federal government has a responsibility to ensure fairness among the states. Minnesota should not be penalized for providing cost-effective health care and improving access to care.

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Wellstone and Ramstad Debate Health Care Issues

At a Medical Alley forum on health care issues February 22, Democratic Sen. Paul Wellstone and Republican Rep. Jim Ramstad agreed on the need to reduce the federal deficit and balance the budget, but clashed over how to do it. To reform Medicare, Ramstad supports means testing, market-based reforms, more options for seniors including medical savings accounts (MSAs), and a crackdown on fraud and abuse. He said the GOP proposed \$168 billion savings in Medicare is necessary to keep the program solvent in the years ahead.

Attacking the GOP-proposed Medicare cuts, Wellstone said such drastic cuts wouldn't be necessary without the GOP budget's "massive giveaways to oil and tobacco and Pentagon contractors." He called the Republican budget "too extreme" because it would reduce educational and job opportunities by cutting funds for vocational training, Head Start, and Pell grants for college students, while giving more money to the Pentagon than the military requested and providing tax cuts. Job training and education are linked to the viability of the Medicare program, Wellstone said, because the middle class will have to be making decent wages to support the Medicare program as more and more people retire.

Wellstone opposes MSAs, which he believes will lead to problems of risk selection, and he insists on the need for adequate reimbursement for physicians and other health care providers. "You can't separate the viability of the providers from the well-being of consumers," Wellstone said. He also favors more home-based care and an emphasis on public health and preventive care.

Despite their differences, however, Ramstad and Wellstone found a good deal of common ground.

Medicare Reimbursement

Both agreed on the unfairness of Medicare reimbursement rates that penalize Minnesota for being cost-effective. "You could have two and a half surgeries at the Mayo Clinic for the cost of one in Florida," Ramstad said. He gave Wellstone credit for fighting on the Senate side for more fairness in the formula to set Medicare HMO rates.

Medical Device Approval

Both legislators agree on the need to speed up the Food and Drug Administration's medical product approval process. Wellstone has written a bill to streamline approval processes that he expects will be included in a bill introduced by Sen. Nancy Kassebaum,

R-Kansas. Ramstad supports Wellstone's proposal, which he called "a good first step, but not a panacea." Ramstad would go further and allow private FDA-certified organizations to perform review for all but high-risk drugs and devices.

Insurance Reform

Both Ramstad and Wellstone support the Kassebaum/Kennedy bill's insurance reforms, which include guaranteed portability of health care coverage and restrictions on health plans' ability to deny coverage because of a preexisting condition. Wellstone said the bill's weakness is that it doesn't restrict the size of premiums. "It won't matter if the law says there can't be discrimination because someone had a bout with cancer, if the premiums are \$8,500 a year." (See related article on page 37.)

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Governors Propose Controversial Medicaid Changes

The National Governors' Association has proposed Medicaid changes that offer a compromise between President Clinton's plan, which calls for retaining the individual entitlement with per-capita limits, and the Republicans' goal of block grants with state flexibility. The president's plan would save an estimated \$59 billion over seven years, and the Republicans' plan \$85 billion. The governors' plan has not been scored, but some critics predict savings as low as \$20 billion over seven years.

The governors' proposal calls for the following Medicaid changes:

- allow states to define who is "disabled;"
- require Medicaid coverage for pregnant women and children up to age 12 whose incomes are less than 133 percent of the federal poverty level (\$10,294 for an individual or \$13,778 for a couple);
- eliminate the phase-in of coverage for adolescents up to age 18;

- allow states to define the amount, scope, and duration of benefits;

- repeal the Boren amendment, which allows providers other than physicians to sue over inadequate Medicaid reimbursement;

- repeal federal limits on state provider taxes; and

- reduce the amount of state money needed to draw down federal matching dollars from 50 percent to 40 percent of all Medicaid spending in a state.

The governors' proposal has been attacked by AIDS and mental health advocates and by the Children's Defense Fund. (See Viewpoint on page 34.)

The Clinton administration has expressed concern as well. According to *BNA's Health Care Policy Report*, Department of Health and Human Services Secretary Donna Shalala told the Senate Finance Com-

Plan continued on page 37

MMA Warns of Inhalant Danger

The Minnesota Medical Association, as part of the Partnership for a Drug-Free Minnesota, has joined a campaign to educate the public about the dangers of inhalant abuse—deliberately breathing in common household products, such as glue, spray paint, markers, or room fresheners, to get high.

At a news briefing in St. Paul February 22, Louis Ling, M.D., an emergency physician at Hennepin County Medical Center, said, "Kids die every year because of inhalant abuse. They don't realize it is dangerous."

In the last year in Minnesota:

- A 23-year-old woman died after she deliberately inhaled the propellant from pressurized whipped cream cans;
- A 16-year-old boy died after he inhaled room freshener; and
- A 27-year-old woman died af-

ter inhaling a volatile lubricant agent.

Many others suffered serious damage, particularly to the brain and central nervous system.

Inhalation abuse is increasing among younger children. A 1995 Minnesota survey found that 8 percent of sixth-graders had tried inhalants, up from 5.3 percent in 1992.

Other members of the Partnership for a Drug-Free Minnesota are the Attorney General's Office, the Chemical Specialties Manufacturers Association, Inc., Eden Children's Project, and the Minnesota Retail Merchants Association (MRMA). Attorney General Humphrey praised the MMA and the other groups for joining this effort. "This is a real partnership. Working together over a period of time, we can make a huge difference."

Humphrey urged the media to give air time to a series of powerful

public service announcements, produced by the partnership. The goal is to raise awareness and teach parents to recognize the indicators of inhalation abuse. "The fact that these substances are so accessible—in the closet, in the cupboard, and on the shelf—makes them more of a problem," Humphrey said.

Following the news briefing in St. Paul, Ling, Humphrey, and representatives of MRMA and Eden Youth Program flew to Rochester, Duluth, and Moorhead where they repeated the program, giving information on how to detect, prevent, and treat inhalation abuse.

The MMA is mailing pediatricians a brochure, "About Inhale-Ants," aimed at children. If you would like to receive this brochure or if you would like more information about inhalation abuse, call Mark Vukelich at the MMA, 612/378-1875 or 800/999-1875.

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Facts About Inhalation Abuse

Sniffers and Huffers

"Sniffers" sniff inhalants through their nose. There are several different techniques. They may place an open bottle of glue or nail polish or a marker close to their nose and inhale, or they may spray chemicals into a bag and sniff. Sometimes they soak a cloth or spray paint or cleaner into a pop can and breathe in the fumes. "Huffers" inhale the fumes through their mouth. There are three main categories of inhalants that are commonly abused: organic solvents, nitrous oxide, and volatile nitrates.

Solvents

Organic solvents include gasoline, paint thinner, spray paints and glues, fabric guards, and types of freon. Inhaling solvents can cause sudden death even when done for

the first time. Solvents can cause the heart to stop or to beat irregularly. They also damage the central nervous system. Easily crossing the blood-brain barrier, solvents when inhaled over time may cause personality changes, numbness and tingling of fingers and toes, tremors, headaches, and loss of memory. Repeated use can eventually cause irreversible brain damage leading to difficulty thinking or concentrating and loss of balance. Solvents may also irritate the nose, mouth, throat, and lungs, making it hard to breathe.

Nitrous Oxide

Nitrous oxide or laughing gas is used as the propellant in whipped cream dispensers. Abusers usually discharge it into a balloon and then inhale it. Lack of oxygen in the lungs rather than the nitrous oxide itself can cause

death. Long-time abuse may cause anemia and nerve damage with a resulting loss of balance, numbness, tingling, and hearing loss. It may also cause irregular heartbeat, shortness of breath, and nausea.

Volatile Nitrites

Butyl nitrate and isobutyl nitrite are sold as room deodorizers. Amyl nitrite is a prescription medication, sometimes called "poppers." Inhalation of volatile nitrites opens blood vessels and can cause dizziness, light-headedness, blurred vision, headaches, nausea, and fainting.

Warning Signs

Physical signs that may indicate inhalant abuse are a red or runny nose; sores, rash, or paint spatters around the mouth and nose; and a chemical smell on the breath.

ANNOUNCEMENTS

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MMA AND ST. OLAF OFFER ETHICS CONFERENCE

The Minnesota Medical Association and the St. Olaf College Office of Continuing Education and Academic Outreach are jointly sponsoring a day-long conference, "Liberal Arts and the Law—Ethics of Health Care Economics: Access, Availability, and Quality," at St. Olaf College in Northfield on May 31. After attending this conference, physicians and attorneys should be able to discuss what happens when medical, legal, and economic interests intersect. They will be able to recognize possible ethical dilemmas and how decisions arising from those dilemmas could affect their practices and professions.

The Minnesota Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The MMA designates this continuing medical education activity for 6.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

For registration information, call Susan Thurston Hamerski at St. Olaf College, 507/646-3629.

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MOAPP FUNDRAISER

The Minnesota Organization on Adolescent Pregnancy, Prevention, and Parenting (MOAPP) will hold its 1996 fundraiser featuring Jane Fonda on April 30. Tickets for the dinner, to be held at the Aveda Institute Ballroom in Minneapolis, are \$150, and tickets for the reception are \$50. For more information, call Maureen Kucera at the Attorney General's Office, 612/297-3494, or Sharon Ruhland, 612/535-2889.

Insurance Reform Bills Advance

The authors of the insurance reform bill S. 1028, Sen. Edward Kennedy, D-Massachusetts, and Sen. Nancy Kassebaum, R-Kansas, are trying to keep their bill free of amendments to preserve its broad bipartisan support. There are 50 cosponsors for the bill, which is endorsed by the American Medical Association and by numerous medical specialty societies. The Kennedy/Kassebaum bill calls for the following reforms:

- limit waiting periods for pre-existing conditions;
- give individuals credit for previous group health plan coverage so they won't have a waiting period if they change jobs;
- require group and individual plans to renew coverage in most cases; and
- require plans to issue coverage regardless of health status to groups and with some restrictions to individuals.

The Kennedy/Kassebaum bill passed the Senate Labor Committee in August 1995, but was blocked from consideration by the full U.S. Senate when Sen. Rod Grams, R-Minnesota, and a few other senators used a "hold," an informal, anonymous tactic to delay action. The Senate is expected to debate the bill after April 15.

The Health Insurance Association of America opposes the Kennedy/Kassebaum bill, claiming it would raise premiums for people who already have individual insurance coverage from 10 percent to 30 percent. These figures are contradicted by the American Academy of Actuaries, which estimates that premiums would increase by no more than 3 percent, and by the Hay Group Inc., which estimates the individual premium would increase by less than 1 percent in the first year and by no more than 3 percent when the maximum number of newly insured people are drawn into the market by the portability provisions.

In the House, the companion bill, H.R. 2893-Roukema, has not been

marked up, but another insurance bill, the ERISA Targeted Health Insurance Reform Act, H.R. 995, introduced by Rep. Harris W. Fawell, R-Illinois, was approved by the House Economic and Educational Opportunities Committee. The Fawell bill includes some portability reforms, but House Democrats oppose the bill because it would preempt stronger state portability and insurance reform laws and it does not guarantee that people who leave the group market will be able to buy individual insurance. The bill would allow small employers to band together to self-insure or fully insure and would reduce the ability of states to regulate such groups.

Instead of trying to pass a clean insurance reform bill, House Republicans are expected to include portability provisions in a more comprehensive bill that would call for medical savings accounts and a higher health insurance tax deduction for the self employed.

A conference committee may have to work out the differences between the tightly focused Senate bill and a more comprehensive House bill.

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Plan continued from page 35

mittee that the combination of lower state matching funds and no restrictions on provider taxes in the governors' proposal could lead to higher federal spending, lower state spending, and lower overall health care spending. The fear is that states would reduce their Medicaid spending and use provider taxes to draw down federal matching money.

Republicans are fleshing out the governors' proposal and putting it into legislative language. GOP leaders plan to push for a combined Medicaid and welfare reform bill based on the National Governors' Association proposals.

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ANNOUNCEMENTS

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**MMA AND BMP SPONSOR
WELLNESS SEMINAR**

The Minnesota Medical Association and the Minnesota Board of Medical Practice are jointly sponsoring a seminar on physician wellness, which will be presented in four locations during April. The seminar will focus on the physician as patient, on preventive measures, and on the role of the Health Professionals Services Program. After attending this seminar, participants should be able to recognize the chemical, mental, and physical health problems of physicians and to construct an effective individual prevention program.

The Minnesota Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The MMA designates this CME activity for 3.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

Dates and locations are as follows: April 10, Duluth; April 16, Bloomington; April 18, Shoreview; and April 24, Rochester. Each seminar begins with a buffet dinner at 5 p.m. The registration fee is \$25. To register, call the Minnesota Board of Medical Practice at 612/642-0538.

Chiros and Nurses Succeed in Senate

Over strong MMA objections, the Senate passed an amendment that would allow chiropractors and advanced practice nurses to perform the required physical examination for truck drivers. The amendment was attached to a Department of Transportation bill, H.F. 1404, that calls for higher speed limits on state highways. In a slight improvement over previous chiropractic proposals, the amendment gives the trucking company the option of naming a specific health care provider to perform the exam.

The chiropractors' bill appeared to be dead when it failed to meet committee deadlines, but the proposal resurfaced as an amendment offered by Sen. Phil Riveness, DFL-Bloomington, on the Senate floor March 18. In the days leading up to the vote, the Minnesota Chiropractic Association and the Minnesota Nurses Association vigorously lobbied the Senate, while the MMA launched a grassroots attempt to block them. The MMA sent out a Legislative Alert and mobilized the Legislative Network asking MMA members to call their senators and explain that chiropractors do not have the training or experience to conduct an adequate physical exam. The Minnesota Truckers Association joined the MMA in strong opposition to the chiropractors' proposal.

Opposing the amendment on the Senate floor, Sen. Linda Berglin, DFL-Minneapolis, chair of the Senate Health Care Committee, said that her committee did not hear this bill because performing a comprehensive physical examination is outside the chiropractic scope of practice in Minnesota. State law restricts chiropractors' practice to noninvasive procedures that are "necessary to make a determination of the presence or absence of a chiropractic condition." Nevertheless, the Senate adopted the amendment on a 36-24 vote. The House did not concur on the amendment so as *The Monitor* goes

to press, the bill is on its way to conference committee. The MMA will continue to strongly oppose the amendment and will urge conferees to delete it.

In discussions with legislators, the chiropractors are minimizing the importance of the exam. They claim the exam is just a brief review of an individual's health history and a cursory check of the truck driver's general appearance and basic systems. The MMA is telling lawmakers that this is not true.

- The truck driver's examination is intended to be a comprehensive examination to detect serious conditions that could impair a truck driver's ability to operate a heavy truck at high speeds on Minnesota's roads and highways.

- Chiropractors are *not* trained to diagnose serious medical conditions such as cardiovascular disease, diabetes, respiratory dysfunction that could interfere with the driver's ability to control a motor vehicle safely, epilepsy, or any other conditions that could lead to loss of consciousness. Chiropractors are not trained primary care providers.

- Federal rule allows chiropractors to sign the required medical exam forms *only* if it is within the scope of practice of each state. The exam is clearly not within chiropractors' scope of practice in Minnesota.

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MMA Promotes Tips on Conflict Resolution

As part of its ongoing campaign against violence, the MMA offers a card with "Heart Healthy Tips on Conflict Resolution," to put in your patient waiting room. The message is sponsored by the Minnesota Medical Association, the MMA Alliance, and the Erickson Mediation Institute. To obtain conflict resolution tips, call Beth Hoheisel at the MMA, 612/378-1875 or 800/999-1875.

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LEGISLATIVE NEWS

PMAP Holds Up Budget Bill

Disagreement about expansion of managed care in rural Minnesota has been a bone of contention for the conference committee on the Health and Human Services funding bill.

The Department of Human Services and Gov. Carlson want to expand the Prepaid Medical Assistance Program statewide within one year to cut MA costs. The Association of Minnesota Counties, however, strongly objects and wants to delay expansion at least until July 1, 1997. The counties fear that when private health plans come into rural counties they will provide health care services for MA recipients but won't cover the other social service needs, which will fall back on the county taxpayers.

The Senate bill would delay expansion until July 1, 1997, unless the county board approved the use of managed care in its county. The House bill would require county boards to take action to stop PMAP from expanding into their counties.

The MMA supports a delay in PMAP expansion to ensure that local communities have a voice in developing a delivery system that will meet the needs of rural MA recipients. "If managed care is to expand in MA, it must allow for flexibility in delivery systems," said David Renner, MMA director of policy and legislation.

There are rumors that Gov. Carlson might veto the appropriations bill if it includes a delay of PMAP. His veto would be difficult to override because the powerful Minnesota Citizens Concerned for Life is opposed to the use of managed care.

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FEAR OF MCCL BLOCKS HEALTH CARE BILLS

Fear of the powerful Minnesota Citizens Concerned for Life has brought progress on most health care legislation to a complete halt. Even bills with absolutely no

language related to abortion services are at a standstill.

Several important MMA bills have stalled for fear they may become vehicles for abortion amendments or because the MCCL opposes them.

- The bill to repeal the growth limits on health care providers and replace them with cost-containment goals has stalled on the House floor despite the overwhelming support of House members. The Speaker of the House is unwilling to let the bill proceed for fear it will become embroiled in abortion battles.

- The MMA-sponsored point-of-service bill to provide consumers a choice of out-of-network coverage has also stalled. The bill passed the Senate, is unopposed in the House, but it has been targeted by the MCCL as a possible abortion amendment vehicle.

- Funding for medical education and research has stalled because the MCCL claims the money will be used to train more abortionists. The MCCL is also concerned about the University of Minnesota's proposed curriculum changes because they include the study of managed care. The MCCL opposes managed care for fear it will lead to rationing care for the elderly.

- The Senate has passed a measure that would require the commissioner of health to evaluate any additional mandated benefits. A similar proposal is blocked in the House because of the possibility of MCCL amendments.

The MMA is trying to gain assurances that no abortion amendments will be offered to these bills so they can proceed.

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TELEMEDICINE PROJECT PROPOSED

Minnesota's Health and Human Services appropriations bill would require the commissioner of human

services to set up a budget neutral telemedicine demonstration project to test the quality and cost-efficiency of devices that monitor patients in their own homes. The project would offer an alternative to hospital care, nursing home care, or home nursing visits. The project's goal is to determine whether home telemedicine services can be a high-quality, lower-cost alternative to in-person visits from nurses or other health care providers. The project may serve acute care or chronic care patients.

The monitoring devices must be capable of providing video and audio communication between the home and a central monitoring station, staffed by a nurse, and must be equipped to monitor vital signs. The project must be budget neutral or save money. DHS would be required to request proposals by August 31, 1996, and to implement the project by December 1, 1996. A preliminary report is due by March 15, 1997, and a final report by December 15, 1997.

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REIMBURSEMENT POLICIES BLOCK TELEMEDICINE

The lack of reimbursement for telemedicine services is a major obstacle to the widespread use of technology, according to a recent report to Congress. The report, "Telemedicine and the National Information Infrastructure," noted that very few third-party payers reimburse providers for telemedicine services. Most telemedicine systems are supported by demonstration grants that don't provide the financial basis for long-term use. The report recommended that the Health Care Financing Administration implement reimbursement policies for telemedicine that would not distinguish between care provided in person and care provided by telecommunication.

A N N O U N C E M E N T S

**1996 GROWTH LIMIT
IS ANNOUNCED**

The Minnesota Department of Health has announced that the actual 1996 growth limit for health care expenditures in Minnesota is 7.4 percent, the same as the projected growth limit. Providers may limit either their increase in revenue per patient or revenue per encounter to 7.4 percent. Effective this year, physicians who comply with the state growth limits by limiting their fees are subject to a growth limit based solely on the regional consumer price index for urban consumers, which is 3.1 percent. The projected growth limit for Minnesota is 6.4 percent for 1997 and 5.7 percent for 1998. The growth limits were announced in the February 12 *State Register*.

Minnesota's growth limits could change. A bill that is moving through the Legislature might repeal the MDH's authority to enforce growth limits, and another bill might allow physicians to use the full growth limit regardless of how they choose to comply. Watch for further developments in *The Monitor* and *The Monitor in Brief*.

**DO YOU HAVE ANY COMMENTS
ON RETROACTIVE DENIAL?**

The MMA Committee on Medical Practice and Planning will consider Resolution 45, dealing with retroactive denials, at its April 16 meeting. Resolution 45, which was referred to the MMA Board of Trustees by the 1995 MMA House of Delegates, asks the MMA to work with third-party payers and the Minnesota Department of Health to establish a mechanism to identify the problems resulting from retroactive denial and to propose solutions to the problems. If you have any comments or examples of problems caused by retroactive denial, please call Janet Silversmith at the MMA, 612/378-1875 or 800/999-1875, so

the committee can take your ideas into consideration.

JOIN MWP FOR GALA EVENING

You are invited to join Minnesota Women Physicians on Saturday, May 11, for an evening of entertainment, dinner, and dancing. Comedienne Susan Vass, author of the best-selling book, *Laughing Your Way to Good Health*, will be the keynote speaker. Vass, who has been described as "a young Erma Bombeck" and "a female Jay Leno," has helped audiences "laugh their way to good health" in over 1,500 appearances from coast to coast. She is a veteran of countless national television and radio appearances and has opened for Robert Goulet, Andy Williams, the Smothers Brothers, and Jay Leno. The evening will begin with cocktails and dinner prepared by D'Amico Catering, and will continue with dancing to the band, "Dr. Bob's Rock." Everyone is welcome! Join your colleagues for an evening of fun in a relaxed, informal setting at the Earle Brown Heritage Center in Brooklyn Center on May 11. The cost will be about \$45 a person. For more information, or to register, call Jennifer Nelson at 612/362-3736 or 800/999-1875.

**FUNDS ARE AVAILABLE FOR RURAL
HEALTH DEMONSTRATION PROJECT**

The Minnesota Department of Health and Regional Coordinating Board 5 are seeking proposals from nonprofit organizations to develop and administer a pilot project to provide information about health coverage and advocacy services to people within RCB 5. One hundred thousand dollars is available to fund this demonstration project for the period July 1, 1996, through June 30, 1997. To obtain a copy of the Request for Applications and an application form, call Kay Markling

at 612/282-6328 or 800/366-5424. Applications are due by April 15, 1996.

CALL FOR A SUMMER INTERN

If you would like to have a high school student or post-secondary school student work as an intern in your clinic or hospital during the summer of 1996, sign up now. Participating hospitals, medical clinics, and physicians employ students between Memorial Day and Labor Day for six to 12 weeks at wages up to \$6 an hour. Employers are reimbursed up to one-half the cost of employing interns. To sign up, call Wendy O'Donnell at the MMA, 612/378-1875 or 800/999-1875. For more information about the program, call Naomi Bowman at the Minnesota Hospital and Health-care Partnership, 612/641-1121 or 800/462-5393.

The Monitor
APRIL 1996

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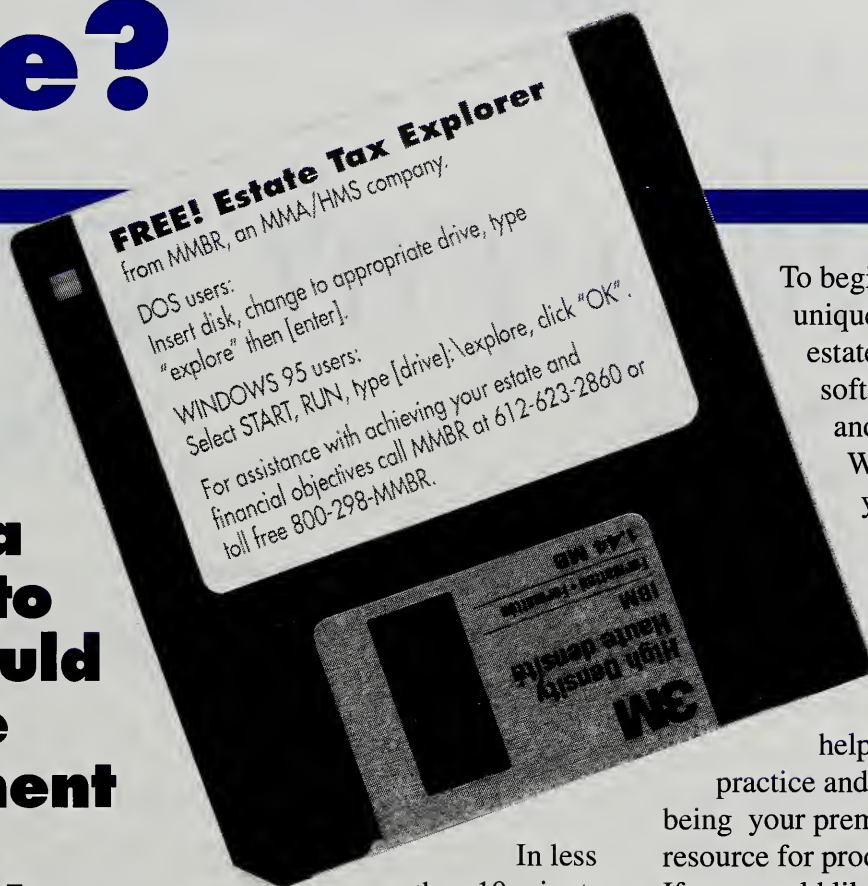
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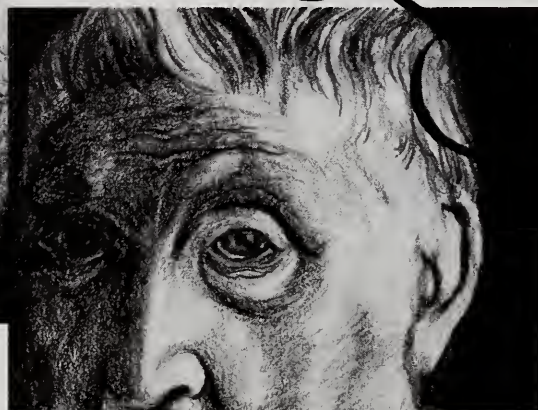
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MMA

Minnesota Medical Association

Mammography Quality Assurance

The federal Mammography Quality Standards Act ensures high-quality, safe mammograms for all women in Minnesota.

Jane Ellen Korn, M.D., M.P.H.

Editor's Note: The American College of Radiology was instrumental in passing new regulations for quality and safety standards for mammography. The regulations appeared onerous to many small rural radiographic facilities. Even some of the large urban installations found the procedures to document the standards time consuming and difficult. In the following article, Jane Korn, M.D., from the Minnesota Department of Health, Cancer Control Section, tells us how well we did in meeting the ACR accreditation standards. I believe you will be as pleased as I was to hear just how well Minnesota met this challenge. Congratulations to all the facilities that are now ACR accredited.

—Barbara P. Yawn, M.D., M.Sc.,
Series Editor

Regular mammography is the best method for detecting breast cancer at its earliest, most treatable stages in women age 50 and older. Randomized trials conducted over the last two decades have shown a one-third reduction in breast cancer mortality among women in this age group who receive annual mammograms. The steady increase in the use of mammography over the last 10 years has been accompanied by a favorable shift in the proportion of early-stage cancers, and evidence shows that deaths from breast cancer may, in fact, be decreasing.¹

The growing demand for breast cancer screening services in the 1980s spawned a huge expansion in the number of facilities offering mammography and, with it, heightened concerns about the safety and quality of screening provided. In 1985, the National Evaluation of X-ray Trends confirmed wide variation in radiation dose and image quality in some 232 facilities surveyed.² Since the sensitivity of mammography is so dependent on technology and technique, the need to set quality standards became increasingly apparent. Clearly, widespread use of poor-quality screening would undermine the purpose of mammography—to detect small, clinically inapparent cancers when they are most treatable.

THE ACR ACCREDITATION PROGRAM

One early response to concerns about a lack of quality and safety standards in mammography was the American College of Radiology's development of the Mammography Accreditation Program (MAP) in 1987. The goals of this voluntary program were 1) to establish quality standards for mammography; 2) to provide a mechanism for mammography sites to voluntarily compare their own performance with national standards; 3) to encourage quality assurance practices in mammography; and 4) to assure reproducibly high-quality images at low radiation doses to the screened woman or patient.³ A unique component of the American College of Radiology (ACR) program was a peer review system of clinical images. Participation in the MAP progressed slowly in Minnesota, particularly among smaller facilities. In 1992, fewer than one-third of Minnesota's mammography facilities were ACR-accredited. This may have been related to the fees associated with the program and to its voluntary nature.

STATE STANDARDS

States began to write rules and regulations on mammography quality assurance in the late 1980s and early 1990s. Minnesota wrote rules addressing mammography quality assurance in 1991 and fully implemented them in 1993. These amended rules included requirements for equipment, film development, phantom image evaluation, and film retention.⁴ In collaboration with the American Cancer Society (ACS), Minnesota also established a mammography facility inspection program. Beginning in 1988, the state's Radiation Control Section conducted annual inspections of virtually all registered facilities, coinciding with ACS' Breast Cancer Detection Awareness screening program. By 1993, 41 states had passed mammography quality assurance legislation and/or regulations, but the major components and the stringency of their requirements varied significantly from state to state.⁵

continued

Table 1

Minnesota's registered mammography facilities

	Non-mobile serviced*	Mobile serviced†	Total active‡
October 1994	185	83	268
January 1995	183	80	263
October 1995	189	82	271

*Includes facilities providing stationary service and/or mobile service at multiple locations. Mobile mammography providers located outside of Minnesota operating within the state are also included.

†Includes facilities that receive the services of mobile mammography units.

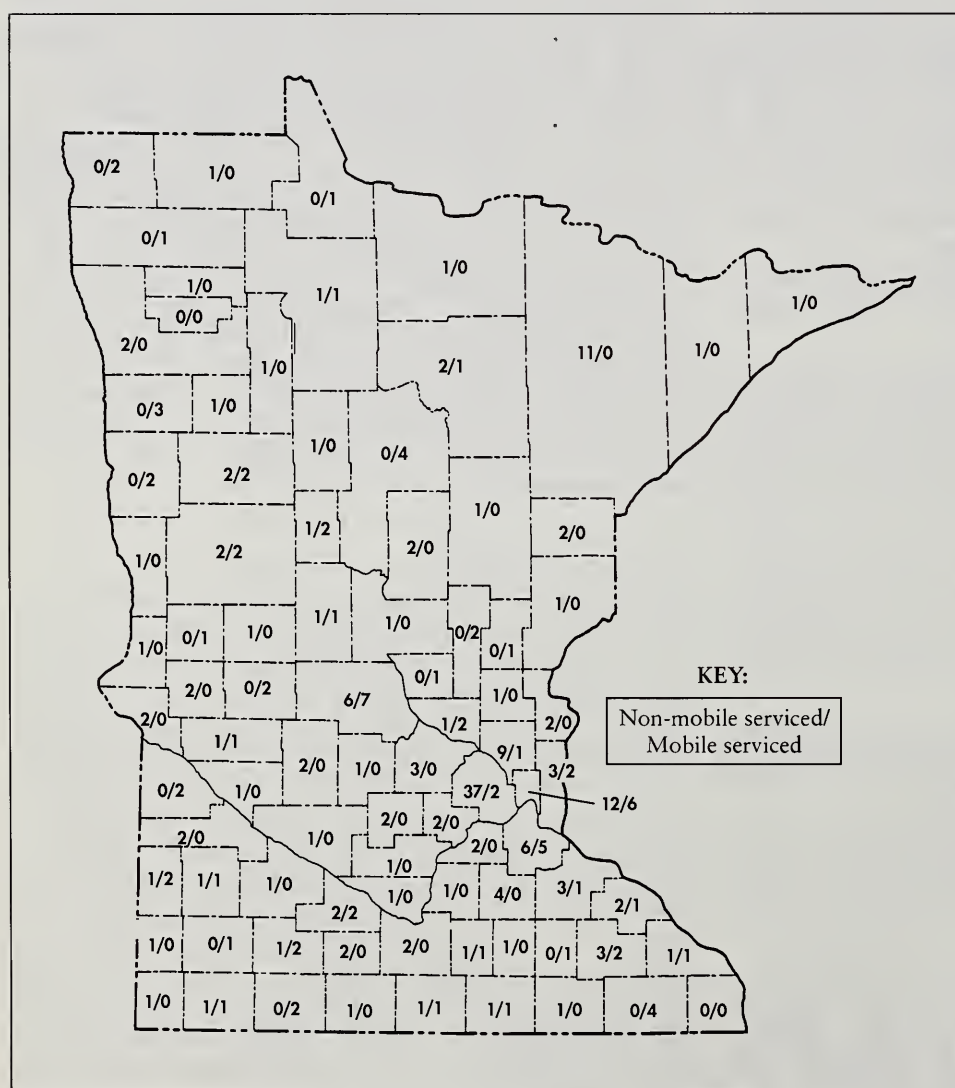
‡Excludes facilities performing only needle localizations.

MEDICARE AND MAMMOGRAPHY QUALITY ASSURANCE

The first piece of federal legislation to address mammography quality assurance was the Omnibus Budget Reconciliation Act of 1990, which extended coverage for mammography screening to Medicare beneficiaries. Interim rules required the use of dedicated mammography equipment, annual surveys by qualified physicists, and training for radiologic technologists and radiologists interpreting mammograms.⁵ But application of these rules was limited to facilities participating in the Medicare program. Facilities could opt out of participation and essentially exempt themselves from the new requirements. The Medicare program was also somewhat hampered by early delays in the training of qualified inspectors. Many facilities received certification from the Health Care Financing Administration solely by attesting to meeting the new requirements. In Minnesota, annual inspections, which already had been occurring, continued under Medicare with minor changes, and few facilities were found to have significant deficiencies.

MQSA CHANGES THE LANDSCAPE

The push for uniform, national standards for mammography quality culminated in passage of the Mammography Quality Standards Act (MQSA) in 1992. This landmark legislation extended federal regulation of mammography quality assurance to all mammography facilities in the United States with the intent of ensuring high-quality and safe mammography for all women. MQSA mandated use of dedicated mammography equipment, annual facility inspections by qualified inspectors, annual on-site surveys by qualified physicists, and accreditation by a federally approved accrediting body. The law also specified personnel qualifications for radiologic technologists, interpreting radiologists, and medical physicists.⁶ Responsibility for overseeing the law was given to the U.S. Food and Drug Administration (FDA), and all facilities were expected to receive FDA certification by October 1994. The ACR became the first federally approved accrediting body, followed by several state-based accreditation programs. For Minnesota, ACR was the only approved accrediting



Figure—Distribution of mammography facilities in Minnesota, October 1995.

body, meaning that all facilities needed to become ACR accredited by October 1994.

CONCERN OVER NEW REQUIREMENTS IN MINNESOTA

When the MQSA passed, fewer than half of Minnesota's mammography facilities were ACR accredited. Health care providers and Minnesota Department of Health (MDH) staff feared that a sizable number of facilities might be at risk for suspension of service in October 1994, the deadline for FDA certification. The lengthy accreditation process was further slowed by a huge influx of new applications to ACR. This was particularly worrisome for Greater Minnesota, where mammography facilities were sparsely distributed. In addition, a large number of rural mammography sites were being served by mobile units; shutdown of even one such unit could reduce access for women in many small, rural communities.

THE IMPACT OF MQSA IN MINNESOTA

To evaluate the potential impact of MQSA on the availability of mammography in Minnesota and to plan targeted interventions to minimize interruption of mammography services, MDH conducted a survey of all eligible facilities five months prior to implementation of MQSA. In May 1994, 82% of the nonaccredited facilities had initiated applications to ACR, the majority having submitted them within the preceding six months. However, only half had progressed to the final stage of clinical image review, and some facilities were submitting clinical images for the second or third time.

The vast majority of facilities surveyed requested technical assistance in the certification process, ranging from interpretation of MQSA's requirements to a review of quality control procedures to help with image evaluation. The MDH subsequently sponsored five workshops for radiologic technologists in collaboration with the Minnesota Society for Radiologic Technologists. The workshops were designed to clarify the ACR's expectations, particularly for submitting clinical images and meeting the MQSA's paperwork requirements.

In January 1995, four months after MQSA was implemented, almost all of the facilities active in 1994 were still providing mammography. Four facilities closed, two in the Twin Cities metropolitan area and two in Greater Minnesota. In all but one instance, either an existing facility or a new one operated in close proximity to the one that closed. One rural community was left without an active mammography site when the sole facility closed in that county. This facility performed 200 to 300 mammograms per year. The mammograms performed at the facilities that closed represented roughly 0.4% of the total 434,923 mammograms reportedly done at Minnesota facilities in 1994. As of October 1995, one year after MQSA was implemented, the number and distribution of mammography facilities in Minnesota showed no appreciable change (see the figure and Table 1).

Table 2

Minnesota Department of Health Guidelines for Early Detection of Breast Cancer

Age 20-39	<ul style="list-style-type: none"> • Clinical breast exam at least every 3 years. • Monthly breast self exam.
Age 40-49	<ul style="list-style-type: none"> • Mammogram every 1-2 years. • Yearly clinical breast exam. • Monthly breast self exam.
Age 50 and over	<ul style="list-style-type: none"> • Yearly mammogram. • Yearly clinical breast exam. • Monthly breast self exam.

Important:

These recommendations are intended for women who have no breast symptoms. See a doctor immediately if you find:

- a breast lump;
- fluid from nipples;
- any other breast changes.

CONCLUSION

Despite the Health Department's and providers' fears, implementation of MQSA has had little impact on the availability of mammography in Minnesota. With a national mandate now in place for high-quality mammography standards, the task at hand for public health and medical practitioners is to ensure that all women of appropriate age receive regular mammography (see Table 2). Increasing utilization of mammography should help to achieve further reductions in morbidity and mortality from breast cancer. MM

Jane Korn is medical director of the Minnesota Breast and Cervical Cancer Control Program (MBCCCP), Cancer Control Section, Minnesota Department of Health. MBCCCP is supported by Cooperative Agreement # U57/CCU506748 with the U.S. Centers for Disease Control and Prevention.

REFERENCES

1. Miller BA, Ries LAG, Hankey BR, et al., eds. SEER cancer statistics review: 1973-1990. Bethesda, Maryland: National Cancer Institute, 1993. NIH Pub. No. 93-2789.
2. Hendrick RE. Mammography quality assurance: current issues. *Cancer* 1993;72:1466-74.
3. McLelland R, Hendrick RE, Zininger MD, Wilcox PW. The American College of Radiology mammography accreditation program. *AJR Am J Roentgenol* 1991;157:473-9.
4. Minnesota Rules, Chap. 4730.
5. Fintor L, Alciati MH, Fischer R. Legislative and regulatory mandates for mammography quality assurance. *J Public Health Policy* 1995;16:81-107.
6. Hoffman FA, Rheinstein PH, Houn F. The Mammography Quality Standards Act of 1992. *Am Fam Physician* 1994;49:1965-70.

Early Detection of Prostate Cancer

Decreasing the Mortality Rate

Physicians can help detect prostate cancer at an early, curable stage by conducting annual examinations and utilizing early detection programs.

Joseph E. Oesterling, M.D.

Editor's Note: In this month's *Public Health Reports*, we are trying something new—two articles covering the pros and cons of a new screening procedure. In the future, we hope to have similar series on other topics and look forward to your comments.

Prostate-specific antigen (PSA) has been surrounded with controversy since it first became commercially available more than five years ago. Yet, after years of testing, enumerable conferences, articles, and opinions, the controversy continues. PSA was once touted as a screening test for all men over age 50 or 60; in the first article, Joseph Oesterling, M.D., director of the Michigan Prostate Institute at the University of Michigan in Ann Arbor, suggests a new, still very broad-based strategy for screening. Conversely, Del Ohrt, M.D., medical director for Blue Cross and Blue Shield of Minnesota, tells why he believes PSA screening should remain in the realm of clinical studies. Read their arguments and make your own decisions.

—Barbara P. Yawn, M.D., M.Sc.
Series Editor

THE REAL FACTS ABOUT PROSTATE CANCER

Decreasing the mortality rate from prostate cancer is one of the most formidable challenges facing medicine today. Many experts argue that widespread screening with subsequent radical prostatectomy would lead to success;¹ others support a less aggressive approach to detection and recommend watchful waiting as effective management.² What should physicians do in this time of uncertainty? Definitive data from prospective, randomized clinical trials are not available to guide the way. To shed light on the controversy, this article reviews what is known about prostate cancer—its natural history, diagnosis, and treatment.³

Prostate cancer is the most common cancer in men today, with more than 315,000 new cases expected to be diagnosed in the United States this year. One of every 10 men in the United States will be diagnosed with prostate cancer in his lifetime. Prostate cancer is the second most common cause of cancer death among men.⁴ In 1996,

approximately 41,000 men will die of prostate cancer in the United States. That is, one man will die of prostate cancer every 15 minutes in this country.

No curative therapy exists for advanced prostate cancer. Therefore, once prostate cancer has escaped the confines of the prostate gland, it must be considered incurable. While excellent palliation can be achieved with androgen deprivation therapy, curative systemic treatments do not exist. Based on scientific data from numerous investigations, it is well known that prostate cancers begin as small, microscopic tumors confined to the prostate—they do not suddenly appear one day as massive tumors having spread throughout the body. If the cancer is *entirely* confined to the prostate and the entire prostate is removed (as with radical prostatectomy), the man will be freed of the cancer. In fact, studies show that men with organ-confined prostate cancer who are managed with radical prostatectomy survive as long as men of similar age who never had prostate cancer.⁵

One apparent way to decrease the mortality rate from prostate cancer would be to 1) diagnose all prostate cancers at an organ-confined stage, and 2) manage all patients with radical prostatectomy. However, certain other issues must be addressed. More men die with prostate cancer than of it.⁶ Therefore, it is not necessary to diagnose and treat all prostate cancers. The problem is that, as of yet, we have no biochemical, genetic, radiographic, or pathologic method for reliably distinguishing aggressive prostate cancer from biologically insignificant disease at the time of diagnosis. Furthermore, prostate cancers, in general, are slow-growing tumors, requiring years to be life threatening. Stamey and colleagues have calculated that small, organ-confined tumors double in size in approximately four years.⁷ Thus, for a 1-cc tumor to be life threatening, a man would have to live an additional 15 years or more. Therefore, an appropriate goal is to diagnose organ-confined prostate cancers in young men. How do we accomplish this task?

DIAGNOSING EARLY PROSTATE CANCER

Prostate cancers that are curable are asymptomatic; thus, the only way to detect a prostate cancer at its early, organ-confined, curable stage is through routine, annual examination. Prostate-specific antigen (PSA) is the most valuable tumor marker available today for diagnosing prostate cancer. Nevertheless, it lacks sufficient sensitivity and specificity to be the "perfect" tumor marker.⁸ Age-specific reference ranges make PSA a more sensitive tumor marker for younger men (under 60 years of age) and a more specific tumor marker for older men (over 60 years of age) (see Figure 1 and the table).⁹⁻¹⁶ While an elevated serum PSA level can detect many prostate cancers, including ones that cannot be identified with digital rectal examination (DRE), some tumors are not associated with an elevated serum PSA value and can only be detected with a DRE. Thus, the most complete evaluation of the prostate gland is achieved with the combined use of serum PSA and DRE.¹⁷ A prostate cancer detected by an abnormal DRE or an elevated serum PSA concentration in a young, healthy man with a life expectancy of 15 years or more is a clinically significant tumor, and definitive treatment should be considered.¹⁸

No data indicate that *screening* for prostate cancer, by whatever diagnostic test, decreases the mortality rate from this disease. Although several randomized clinical trials are underway in Europe and the United States, results from these investigations are many years away. In the meantime, physicians should: 1) participate in "early detection" programs, which differ from "screening" programs,* and 2) focus on young men with a life expectancy of 15 years or more and evaluate them diligently and rigorously using DRE and age-specific reference ranges for serum PSA. Who, then, are the candidates for early detection programs?

IDENTIFYING HIGH-RISK GROUPS

Three groups of men are appropriate for early detection programs: 1) black men; 2) men with a family history of prostate cancer by either the maternal or paternal lineage, who are 35 years of age or older

and have a life expectancy of 15 years or more; and 3) men 50 years of age or older with a life expectancy of 15 years or more.¹⁹⁻²⁰ Men with life expectancies of at least 15 years should know if they have prostate cancer and, if so, whether the tumor is organ-confined so they can decide with confidence whether to pursue definitive treatment. To reduce the mortality rate associated with prostate cancer, physicians must focus early detection efforts on young men, identify prostate cancers at an organ-confined stage, and administer treatments determined effective for that stage of the disease (such as radical prostatectomy).²¹ Physicians must resist the urge

Table

Serum PSA and patient age

Age range (years)	Median value (ng/ml)	Interquartile range* (ng/ml)	Reference range† (ng/ml)
40-49	0.7	0.5-1.1	0.0-2.5
50-59	1.0	0.6-1.4	0.0-3.5
60-69	1.4	0.9-3.0	0.0-4.5
70-79	2.0	0.9-3.2	0.0-6.5

*25th-75th percentile

†Upper limit defined by the 95th percentile

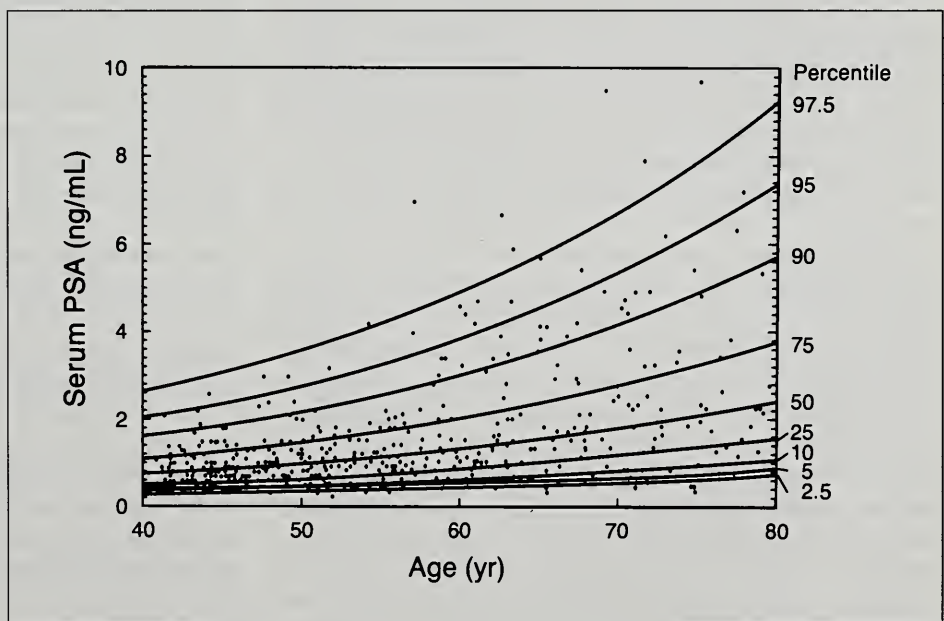


Figure 1—Serum prostate-specific antigen (PSA) concentration as a function of patient age. Scattergram of individual serum PSA values for 471 men, with the nomogram demonstrating 2.5th, 5th, 25th, 50th, 75th, 95th, and 97.5th percentiles for serum PSA according to age. (Reprinted with permission from Oesterling JE, Jacobsen SJ, Chute CG, et al. Serum prostate-specific antigen in the community-based population of healthy men: establishment of age-specific reference ranges. JAMA 1993;270:860.)

*In early detection programs, the men are informed and they agree to participate, knowing the risks and benefits of being involved. In screening programs, all men who meet pre-determined criteria are evaluated. There is no discussion informing the participant of the risks and benefits. Whoever meets the criteria is evaluated.

PSA	DRE	Diagnostic Action
≤ Age-specific range	Negative	→ Annual PSA and DRE
> Age-specific range	Negative	→ TRUS: Biopsy visible lesions; sextant biopsy of remaining prostate, with two cores containing transition zone tissue
Any value	Positive	→ TRUS: Biopsy palpable and visible lesions; sextant biopsy of remaining prostate

Figure 2—Diagnostic algorithm that employs digital examination and serum prostate-specific antigen to detect early, clinically significant prostate cancers. Age-specific reference ranges are 0.0-2.5 ng/ml for 40-49 years, 0.0-3.5 ng/ml for 50-59 years, 0.0-4.5 ng/ml for 60-69 years, and 0.0-6.5 ng/ml for 70-79 years. (Reprinted with permission from Oesterling JE, Cooner WH, Jacobsen SJ, et al. The influence of patient age on the serum prostate-specific antigen concentration: an important clinical observation. *Urol Clin North Am* 1993;20:627.)

to treat truly incurable cancers and to surgically manage men whose life expectancy is limited.

AGE-SPECIFIC REFERENCE RANGES

Age-specific reference ranges for serum PSA are important and clinically useful. With a single reference range of 0.0-4.0 ng/ml for all men, PSA evaluates men of all ages the same, as if prostate cancer has the same clinical significance for a young man as for an older man. While the prevalence of prostate cancer increases with advancing age, its clinical significance decreases—an important point that cannot be ignored. The age-specific reference ranges help the clinician to focus on younger men (less than 60 years old) and to evaluate them more diligently and strictly.

Using the narrower (age-specific, “normal”) reference ranges for men younger than 60 years of age significantly increases the *sensitivity* of PSA for detecting prostate cancer in these men. This means for men in their 40s and 50s, the age-specific reference ranges should lead to the detection of more prostate cancers. The additionally detected cancers will be found in men in their 40s with a serum PSA value between 2.5 ng/ml and 4.0 ng/ml, inclusive, and in men in their 50s with a serum PSA value between 3.5 ng/ml and 4.0 ng/ml, inclusive. To determine how many more cancers will be diagnosed and the pathologic characteristics of these tumors, Criley and colleagues examined the medical records of 1,109 consecutive men between 40 and 59 years of age who underwent radical prostatectomy at the Johns Hopkins Hospital or the Mayo Clinic.²² Of the 147 patients between 40 and 59 years of age, 23 (16%) had a serum PSA concentration between 2.5 and 4.0 ng/ml, inclusive; of the 962 patients between 50 and 59 years of age, 42

(5%) had a serum PSA level between 3.5 and 4.0 ng/ml, inclusive. Thus, the age-specific reference ranges would have detected 65 patients (6%) with prostate cancer that would not have been identified with the standard range of 0.0-4.0 ng/ml. A review of the pathologic characteristics of these additionally detected cancers revealed that 55 (85%) were potentially curable, demonstrating either organ-confined disease or capsular perforation only with a Gleason score of six or less.

The additional tumors identified using the age-specific reference ranges are the very cancers clinicians need to detect. The cancers are potentially curable by pathologic criteria and occur in young men who will remain at risk for many years. Because these men in their 40s and 50s have an additional life expectancy of 30 to 35

years, they will benefit significantly from definitive treatment. Thus, these preliminary data indicate that the narrower age-specific reference ranges for men less than 60 years of age make PSA a more clinically useful tumor marker for this age group.

THE DIAGNOSTIC ALGORITHM

When performing a prostatic evaluation, it makes no difference whether the DRE is performed first or the serum PSA concentration is determined first. A routine, diagnostic DRE has no clinically significant effect on the serum PSA concentration. If the DRE is negative and the serum PSA concentration is within the age-specific reference range (see the table), the patient should return the following year for another prostatic evaluation. If the DRE is unremarkable and the serum PSA level is elevated above the age-specific reference range (see the table), the patient should undergo a transrectal ultrasound (TRUS)-guided biopsy of the prostate gland. If a hypoechoic area is identified, it should be biopsied. In addition, a systematic, sextant biopsy of the remaining prostate tissue should be performed, making sure that two cores contain tissue from the transition zone. If the DRE is positive for induration or nodularity, irrespective of the serum PSA concentration, a TRUS-guided biopsy of the prostate should be performed. The palpable abnormality noted on DRE should be biopsied, as should any hypoechoic area identified on TRUS. In addition, a systematic, sextant biopsy of the remaining prostate tissue should be carried out. This diagnostic approach for detecting early-stage, curable prostate cancer in young men is summarized in Figure 2.

Future research may help define race-specific reference ranges for PSA.²³ PSA exists in the serum in two major forms—free and complexed to alpha₁-anti-

chymotrypsin.²⁴⁻²⁵ Men with BPH have more of the free form, whereas patients with prostate cancer have more of the complexed form in the serum. The ability to measure the quantity of each of these two forms may make PSA a more *specific* tumor marker for distinguishing between men with BPH and men with an early, curable prostate cancer.²⁶

SUMMARY

In conclusion, prostate cancer is a major menace to Western society. Since prostate cancer is asymptomatic in the early stages and no curative therapy exists for the advanced stages, our only hope for decreasing the mortality rate from prostate cancer is through early detection programs. Young men with life expectancies of 15 years or more should participate in early detection efforts. These men should be evaluated diligently, through the combined use of DRE and the newly described age-specific reference ranges. Radical prostatectomy, when performed on a man with a life expectancy of 30 to 35 years who has organ-confined prostate cancer, is an effective treatment for the No. 1 cancer in men today.

With limited health care dollars available in the future for the diagnosis and management of prostate cancer, physicians will be forced to become selective with their diagnostic and therapeutic efforts. It is much less expensive to treat a young man with early-stage, curable prostate cancer than to manage an elderly man terminally ill from advanced prostate cancer. Without question, young men will be the target of our early detection efforts and the ones who will benefit.

MM

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REFERENCES

- Walsh PC. Prostate cancer kills: strategy to reduce deaths. *Urology* 1994;44:463.
- Johanson J-E. Watchful waiting for early stage prostate cancer. *Urology* 1994;43:138.
- Walsh PC. The natural history of localized prostate cancer: a guide to therapy. *Campbell's Urology Update* 1995;13:1.
- Wingo PA, Tong T, Boiden S. Cancer statistics, 1996. *CA* 1996;47:8.
- Jewett HJ, Bridge RW, Gray GF Jr., Shelley WM. The palpable nodule of prostatic cancer: results 15 years after radical excision. *JAMA* 1968;203:403.
- Cupp MR, Oesterling JE. Prostate-specific antigen, digital rectal examination, and transrectal ultrasonography: their roles in diagnosing early prostate cancer. *Mayo Clin Proc* 1993;68:297.
- Schmid H, McNeal JE, Stamey TA. Observations on the doubling time of prostate cancer: the use of serial prostate-specific antigen in patients with untreated disease as a measure of increasing cancer volume. *Cancer* 1993;71:2031.
- Oesterling JE. Prostate-specific antigen: a critical assessment of the most useful tumor marker for adenocarcinoma of the prostate. *J Urol* 1991;145:907.
- Oesterling JE, Jacobsen SJ, Chute CG, et al. Serum prostate-specific antigen in a community-based population of healthy men: establishment of age-specific reference ranges. *JAMA* 1993;270:860.
- Collins GN, Lee RJ, McKelvie GB, Rogers AC, Hehir M. Relationship between prostate-specific antigen, prostate volume, and age in the benign prostate. *Br J Urol* 1993;71:445.
- Dalkin BL, Ahmann FR, Kopp JB. Prostate-specific antigen levels in men older than 50 years without clinical evidence of prostatic carcinoma. *J Urol* 1993;150:1837.
- Stone NN, Blum DS, DeAntoni EP, et al. Prostate cancer risk factor analysis among >50,000 men in a national study of prostate-specific antigen (PSA). *J Urol* 1994;151:278A.
- Weichert-Jacobsen K, Tillmann L. Clinical significance of prostate-specific antigen age-specific reference ranges. *J Urol* 1995;153:465A.
- Stenman U-H, Oesterling JE. Impact of tumor doubling time (DT) and age-based reference values for PSA on prostate cancer (PCa) screening outcome. *J Urol* 1995;153:505A.
- Speights VO Jr., Brawn PN, Foster DM, Spiekerman AM, Kuhl D, Riggs MW. Evaluation of age-specific normal ranges for prostate-specific antigen. *Urology* 1995;45:454.
- Oesterling JE, Kumamoto Y, Tsukamoto T, et al. Serum prostate-specific antigen in a community-based population of healthy Japanese men: lower values than for similarly aged Caucasians. *Br J Urol* 1995;75:347.
- Oesterling JE. Prostate-specific antigen: improving its ability to diagnose early prostate cancer. *JAMA* 1992;267:2236.
- Oesterling JE, Suman VJ, Zincke H, Bostwick DG. PSA-detected (clinical stage T1c or BO) prostate cancer: pathologically significant tumors. *Urol Clin North Am* 1993;20:687.
- American Urological Association policy statement: early detection of prostate cancer and use of transrectal ultrasound. In: 1992 policy statement book. Baltimore: American Urological Association, 1992.
- Mettlin C, Jones G, Averette H, Gussberg SB, Murphy GP. Defining and updating the American Cancer Society guidelines for the cancer-related checkup: prostate and endometrial cancers. *CA* 1993;43:42.
- Zincke H, Bergstralh EJ, Blute ML, et al. Radical prostatectomy for clinically localized prostate cancer: long-term results of 1,143 patients from a single institution. *J Clin Oncol* 1994;12:2254.
- Criley SR, Partin AW, Zincke H, Walsh PC, Oesterling JE. Standard reference ranges versus age-specific reference ranges for PSA among 3,937 men with clinically localized prostate cancer. *J Urol* 1994;151:449A.
- DeAntoni EP, Crawford ED, Oesterling JE, Ross CA. Age- and race-specific ranges for prostate-specific antigen from a large, community-based study. *Urology*, to be published.
- Stenman U-H, Leinonen J, Alfthan H, Rannikko S, Tuhkanen K, Alfthan O. A complex between prostate-specific antigen and alpha₁-antichymotrypsin is the major form of prostate-specific antigen in serum of patients with prostatic cancer: assay of the complex improves clinical sensitivity for cancer. *Cancer Res* 1991;51:222.
- Christensson A, Björk T, Nilsson O, et al. Serum prostate-specific antigen complexed to alpha₁-antichymotrypsin as an indicator of prostate cancer. *J Urol* 1993;150:100.
- McCormack RT, Rittenhouse HG, Finlay JA, et al. Molecular forms of prostate-specific antigen (PSA) and the human kallikrein gene family: a new era. *Urology* 1995;45:729.

Does Screening With Prostate-Specific Antigen Improve Outcomes?

It's time we end the PSA debate with well-designed clinical studies, says this BCBSM medical director.

Del Ohrt, M.D.

Does prostate-specific antigen (PSA) increase the quality or length of life? Odds are that the answer is not much, if at all. I base my opinion on the consistent failure of individuals with the greatest personal interest in the debate to convincingly demonstrate the value of interventions triggered by a positive PSA.

A variety of organizations already have summarized the existing scientific literature on PSA and early detection of prostate cancer through various types of screening approaches, including the U.S. Preventive Services Task Force (USPSTF),¹ the Office of Technology Assessment,² the Health Technology Advisory Committee of the Minnesota Health Care Commission,³ the Institute for Clinical Systems Integration,⁴ and a number of payers. Only the American Cancer Society⁵ and the American Urological Association⁶ have adopted positions supporting screening.

The debate on this very important clinical question has been going on since 1988, beginning in my early years as medical director responsible for medical policy at Blue Cross and Blue Shield of Minnesota. At that time, no one understood the concept of outcomes well enough to carry on a meaningful discussion about the contribution that a positive PSA would have on short-term, intermediate, and long-term outcomes. BCBSM staff agreed that PSA might help find more men with prostate cancer. However, the natural history of the disorder, which generally affects older men and follows an indolent course in most, raised many questions about the value of early detection through screening programs. The value of treatment for prostate cancer was unclear. We can all agree that many men die with prostate cancer, but relatively few die from it.

We also can agree that prostate cancer is a serious public health problem that deserves attention. The question is, how much attention, in what form, and at what price to purchasers and payers? Efforts to balance the federal budget will force us to carefully consider the value of screening in general; PSA is just one example. Government can only spend the same dollar once. Deserving health care benefits will almost certainly have to

compete with one another as we come to grips with the costs of Medicaid and Medical Assistance. Only the most deserving programs and tests will survive.

I do not offer an argument based on the literature. Others already have examined the evidence—or lack of evidence. Most recently, the USPSTF concluded: "Routine screening for prostate cancer with digital rectal examinations, serum tumor markers (e.g., prostate-specific antigen), or transrectal ultrasound is not recommended."¹ They based their conclusion on several concerns, including 1) failure to demonstrate reduced morbidity and mortality, 2) unclear value added by radical prostatectomy or radiation, and 3) unclear role of lead time (survival appears better because the tumor was detected earlier in its course) and length time bias (screening detects a disproportionate number of cases with slow-growing tumors). Even if the tests used in detection had better sensitivity, specificity, and predictive value, the net benefit of treatment would still need to be considered.

The BCBSM Foundation funded in the late 1980s a retrospective study of Olmsted County residents who had an elevated PSA in an attempt to determine whether early detection and aggressive treatment improve survival.⁷ The study found an increase in the incidence of prostate cancer, which would be expected from a large-scale screening program. This rise in incidence was predicted to plateau. The researchers suggested that finding cases earlier might reduce mortality, but the data did not clearly show this. The results have been inconclusive, primarily because prostate cancer is a slow-growing malignancy. Additional years of follow-up will be necessary to identify clear outcomes.

But mortality is not the only outcome of interest. Perhaps most important is the significant morbidity resulting from both radical prostatectomy and radiation. The typical series of events following an abnormal PSA is expensive both in human misery and in dollars. Incontinence, impotence, and stricture secondary to treatment are depressingly common. And the published reports describing these problems are from centers with the most experience and, therefore, presumably the

fewest complications.

Why are we engaged in the PSA debate at such a basic level after so many years? Because we have continued to ask the wrong questions and, as a result, have failed to produce the evidence necessary to end the debate. Many approaches so far have failed to advance the science of medicine or improve patient care. The insight we need will not come from physicians adopting the PSA test based on faith before evidence has proven its value, from lawyers suing insurance companies, from clinics inaccurately coding claims to get them through the system, or from the public petitioning legislators for a mandate.

Let me share with you a simple solution that would benefit everyone—a solution proposed by BCBSM almost 10 years ago. Payers could fund well-designed clinical trials that enroll enough patients to provide answers years down the line based on qualified research. Instead of arguing over a story told by poorly designed studies, we could all invest in finding the truth.

How would this work? Experts in research design and statistics would assist physicians with a background in research, and payers would contribute the finances. Payers would spend premium dollars on care with a dual purpose: meeting patient expectations and furthering the legitimate scientific interests of medicine. Dollars would be spent much as they are today, but with the added benefit of defining the value of PSA testing and treatment. This could end the present situation, which consists of debate between physicians (primarily urologists) and payers, confused and dissatisfied members of health

plans, and the ever-present threat of a mandated benefit. Cohort studies are now underway but won't be completed for 10 or more years.

We don't always make good choices. Cohort studies that could have started in 1988 would almost be completed now, and we might have solutions to this dilemma and a model for asking and answering the right questions about future screening tests. MM

Del Ohrt is medical director for Blue Cross and Blue Shield of Minnesota.

REFERENCES

1. U.S. Preventive Services Task Force. Guide to clinical preventive services. 2nd ed. Baltimore: Williams and Wilkins, 1996.
2. Office of Technology Assessment. Costs and effectiveness of prostate cancer screening in elderly men. Washington, D.C.: Government Printing Office, 1995. Publication No. OTA-BP-H-145.
3. Health Technology Advisory Committee. Final technology evaluation report: prostate specific antigen as a routine screening test for prostate cancer in asymptomatic men. St. Paul, Minnesota: Minnesota Health Care Commission, Minnesota Department of Health, June 1995.
4. Institute for Clinical Systems Integration. Prostate specific antigen as a screening test for prostate cancer. Minneapolis: Institute for Clinical Systems Integration, 1993.
5. American Cancer Society. Guidelines for the cancer-related checkup: an update. Atlanta: American Cancer Society, 1993.
6. American Urological Association. Executive committee report. Baltimore: American Urological Association, January 1992.
7. Jacobson SJ, Katusic SK, Bergstrain EJ, et al. Incidence of prostate cancer diagnosis in the eras before and after serum prostate-specific antigen testing. JAMA 1995;274:1445-9.

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Mandates for Unproven Health Care Interventions

Spurred by the Legislature's mandate requiring health plans to cover ABMT for breast cancer, the Minnesota Center for Health Care Ethics plans to recommend ways to improve public policy formation.

Karen G. Gervais, Ph.D., and Reinhard Priester, J.D.

Cutting-edge medical innovation is creating tension between the old medicine and the new—between the traditional fee-for-service health care system and today's managed care-dominated marketplace. As yet, there is no agreed-upon or coherent policy approach for determining whether to cover new technologies while in development or transition to therapeutic use. The Minnesota Center for Health Care Ethics,* an academic, clinical, and policy consortium founded in 1994, is currently conducting a project called "Coverage of Unproven Health Care Interventions." The goal is to recommend ways to improve the decision-making process for public and private policies regarding coverage for unproven health care interventions. The project will use Minnesota's 1995 mandate for autologous bone marrow transplant coverage as a case study.

THE ABMT MANDATE

The Minnesota Legislature mandated in 1995 that all private health insurance plans in Minnesota cover

the cost of high-dose chemotherapy and autologous bone marrow transplants (HDC/ABMT) for breast cancer. Legislatively mandated health care is inherently provocative; it suggests that politicians know better than physicians and their patients the best health care options, and better than researchers, epidemiologists, and health policy specialists how to meet the population's interests.

But some people argue that legislative mandates are necessary in a market-driven health care delivery system. They are concerned that business goals are increasingly compromising the pursuit of societal health care goals and restricting patient access to legitimate health care options in ethically unjustified ways. The combination of financial and medical decision-making associated with health maintenance and managed care organizations has raised a troubling specter—that financial considerations might lead organizations to deny coverage for a medical intervention that is not only personally desirable, but also personally essential. This threat sparked the fuse that ignited last year's legislative mandate for ABMT.

Influenced by powerful personal testimony from a few patients who had undergone ABMT and were now in remission, and others who could not obtain ABMT unless their insurance would cover its expense, the Legislature overwhelmingly passed the mandate. However, the ABMT mandate invites ethical and policy

analysis for several reasons:

- It targets an intervention that is unproven and under clinical investigation;
- The mandate's narrow focus on a costly and unproven rescue intervention potentially undermines broader social efforts to contain costs and promote efficiency;
- The targeted intervention was considered in isolation from a comprehensive approach for preventing, diagnosing, and treating breast cancer;
- The legislative decision-making process did not consider alternative policy options and did not utilize legislatively created mechanisms to evaluate health interventions (e.g., the Health Technology Advisory Committee);
- The mandate generates an unfair private/public disparity in coverage by affecting only those enrolled in private health plans (35 percent of the Minnesota population), leaving the self-insured (31 percent), the publicly insured (25 percent), and the uninsured (9 percent) outside the mandate's dominion (based on 1993 statistics);
- The mandate may undercut, or at a minimum confuse, the effort to arrive at a standard benefits set; and
- The threat of "drive-by" mandates may encourage further flight to self-funded insurance arrangements, undermining socially valuable mandates.

While legislative mandates may be a very useful and appropriate pol-

*The Minnesota Center for Health Care Ethics was created through a partnership between Fairview Riverside Medical Center, HealthEast, the College of St. Catherine, and the Sisters of St. Joseph of Carondelet. The center's mission is to promote ethically informed health care decision-making.

icy tool in some circumstances (e.g., the federal COBRA mandate for continuation of coverage after loss of employment), they may be inappropriate, even harmful, for both the population and individual patients in other circumstances.

QUESTIONS TO ADDRESS

Questions about covering potentially promising health care interventions, particularly for patients with a life-threatening condition, are an important starting point for analyzing the appropriateness of mandates for unproven interventions. How should policy be formed regarding coverage for unproven interventions? Who should be involved in designing such policy? What questions should be asked along the way to forming sound policy?

First, we must address broad questions about the overarching societal goals associated with emerging health care technologies. What are the societal goals and objectives served by investigating unproven interventions? What societal goals and objectives should shape policy regarding coverage for unproven interventions? What specific features of patients' conditions (and of the interventions themselves) might warrant special policy responses (e.g., that the intervention is the only remaining potentially beneficial response to a lethal condition)? Responses to these broader questions will frame the discussion about appropriate criteria, processes, and decision-makers concerning coverage.

It is important to draw a distinction between the social policy questions and the insurance policy questions. Social policy questions include, for example: What morally relevant criteria should be considered in decisions regarding whether and under what circumstances access to unproven interventions is required, optional, or inappropriate? Based on these criteria, when and under what circumstances should insurers and health plans cover an unproven intervention? When, if ever, is a legislative mandate for an unproven intervention ethically justified? Should policies for unproven interventions differ for public and private payers?

Insurance policy questions include these: If, on the basis of social policy considerations, insurers and health plans have a responsibility to provide coverage for an unproven intervention, what criteria should be used to determine whether they should in all cases provide coverage, or whether they should be permitted to provide conditional coverage (e.g., coverage conditioned on participation in a randomized clinical trial)? Who should participate in making coverage decisions? When and under what circumstances should insurers and health plans help fund evaluations of unproven interventions? Which evaluative research costs should insurers and health plans pay for—standard patient care costs, costs of the unproven interventions, administrative research costs?

These questions have not been systematically addressed, and there is no consensus on how to resolve them. However, Minnesota's ABMT mandate is an excellent lens through which to examine them.

COVERAGE FOR UNPROVEN INTERVENTIONS PROJECT

Concerned that Minnesota's ABMT mandate does not represent ethically informed policymaking (that it, in fact, has the potential to disrupt appropriate clinical trial mechanisms and expose individual patients to harm), the Minnesota Center for Health Care Ethics initiated its project on coverage for unproven health care interventions, with special attention focused on ABMT for breast cancer. We believe public policy in this area should be guided by four central purposes. First, it should reflect a population-based, disease-management approach. That is, it should strive to improve care for all persons in a population at risk for a particular disease, rather than for one subpopulation at the possible expense of another. Second, public policy should rely on the education and active participation of all relevant stakeholders, including the public. Third, it should encourage cooperative data gathering and sharing, so that coverage policies and patient treatment decisions rest on firm empirical bases.

BILLS ASK LEGISLATURE TO MANDATE HEALTH CARE COVERAGE

Several bills to mandate health benefits have come before the Minnesota Legislature over the years, prompting legislators to propose that the commissioner of health review such bills before they go to the Legislature for consideration. Last year, following emotional testimony, the Legislature passed a bill mandating autologous bone marrow transplants for breast cancer patients. This year, the Legislature has considered bills requiring insurers to cover at least 48 hours of postpartum care, treatment for injuries caused by domestic violence, prostate cancer screening with the prostate-specific antigen test, and treatment for diagnosed Lyme disease. Minnesota statutes already include more than 30 such mandates, second only to Maryland, according to a recent Twin Cities *Star Tribune* article.

This session, Sen. Sheila Kiscaden, R-Rochester, and Rep. Roger Cooper, DFL-Bird Island, introduced a bill that would require the commissioner of health to advise the Legislature on the social and financial impact of mandating a treatment or service and the scientific evidence proving its value. When a bill is proposed, the commissioner would determine the level of review needed and consult with a resource such as the Minnesota Health Care Commission's Health Technology Advisory Committee. As *Minnesota Medicine* goes to press, the bill is still being considered at the Legislature.

Finally, policy formation should be founded on a thorough consideration of policy alternatives.

Within these parameters, the project now underway will develop specific recommendations for decid-

ing when to cover unproven interventions. Over the next year, the project will generate a white paper, a position paper, and patient materials, which will include a model for informed consent to participate in

research on an unproven intervention. The white paper will delineate 1) the ethical and policy problems raised by legislative mandates for unproven interventions such as ABMT for breast cancer, and 2) alternative policy options for covering unproven interventions, with specific attention to the role of insurers and health plans. This white paper, intended for all relevant stakeholders, including the "informed public," will provide the foundation for developing the position paper, which will recommend processes for deciding whether and how unproven interventions should be covered. It will specify the role of insurers and health plans, providing criteria for assessing their responsibility in covering unproven interventions.

The project also will design a model for patient informed consent to an unproven intervention like ABMT. Many people are concerned that the legislative mandate will lead the public to consider ABMT the treatment of choice, despite its unproven, potentially harmful effects. The center will address this issue by constructing guidelines for patients' "informed choice," which could be used as part of a treatment protocol. The center will create educational materials to guide and strengthen informed consent negotiations between clinicians and patients contemplating ABMT as a treatment for breast cancer. This will help patients make ethically informed decisions to seek or reject this unproven intervention.

In preparation for the white paper, to be completed by June 1996, we have convened a task force consisting of ethicists, health care and managed care professionals, legislators, researchers, and policy specialists (see list of participants at the end of this article). The group is studying and discussing a broad range of issues to form a well-grounded policy recommendation about the responsibility of insurers and health plans to cover costs associated with patients' access to unproven interventions.

CONCLUSION

Tension surrounding the question of covering unproven health care inter-

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ventions is high. In part, this tension results simply from the transition from the old medicine to the new. However, the market-driven changes in health care are continuing largely without rules. Small wonder, then, the appeal of ad hoc policies like legislative mandates to fill the void. Yet mandates do not effectively encourage or contribute to a responsible system overall.

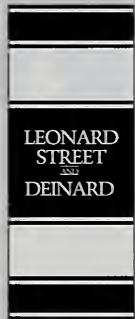
The stakeholders are many, and the stakes are high for each: patients and families, clinicians, researchers, drug and device manufacturers, employers, payers, politicians, and even ethicists and policymakers. It is improper to make policy regarding unproven interventions using the micro-political tool of a legislative mandate, when a comprehensive analysis and strategy are required. Developing such a strategy will test our ability to balance the multiple goals of quality care, efficiency, innovation, equity, and compassion. **MM**

Karen Gervais is director and Reinhard (Jake) Priester is associate for health policy at the Minnesota Center for Health Care Ethics.

THE UNPROVEN
INTERVENTIONS TASK FORCE

Members are as follows: Craig Christianson, M.D., UCARE Minnesota; Ronald Cranford, M.D., Hennepin County Medical Center; Kathy Faber-Langendoen, M.D., University of Minnesota Hospital and Clinic; Gwen Halaas, M.D., HealthPartners; Rev. Scott Hinrichs, HealthEast Corp.; Cindy Holmsten, R.N., Blue Cross and Blue Shield of Minnesota; Richard Korman, J.D., Metropolitan Hospital and Healthcare Partnership; Margaret MacRae, M.D., Fairview Southdale Hospital; Ruth Mickelsen, J.D., Allina Health System; Steven Miles, M.D., Center for Biomedical Ethics, University of Minnesota; Kathleen Ogle, M.D., Park Nicollet Medical Center; Anita Pampusch, Ph.D., College of St. Catherine; Thomas Pender, J.D., Minnesota House of Representatives Research Department.

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People and Places Making Medical News

People

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Center for Biomedical Ethics Director

The University of Minnesota Center for Biomedical Ethics has named **Jeffrey P. Kahn, Ph.D.**, its new director, pending approval by the Board of Regents, effective August 1996. Currently, Kahn is director of the Graduate Program in Bioethics at the Medical College of Wisconsin in Milwaukee.

Kahn's areas of expertise are ethics and health policy, ethical issues in genetics, and research ethics. He has a Ph.D. in philosophy specializing in bioethics from Georgetown University, a master's of public health degree from Johns Hopkins University, and a bachelor's degree in microbiology from UCLA. He joined the Medical College of Wisconsin in 1992 to build a master's program in bioethics—the first of its kind in a medical school. In addition, from April 1994 to October 1995, he was associate director of the White House Advisory Committee on Human Radiation Experiments, established by President Clinton.

"Kahn has been sought after by prestigious institutions," said Frank Cerra, M.D., dean of the Medical School. Kahn replaces **Arthur Caplan, Ph.D.**, who directed the center from 1987 to 1994. Associate Director **Dianne Bartels** has served as acting director since 1994. (Watch for the June issue of *Minnesota Medicine* for more on the center and its new director.)

Saint John's University Alumni Achievement Award

Robert Christensen, M.D., is the 1996 recipient of the Saint John's University Alumni Achievement Award. The award recognizes Christensen, a 1962 graduate, for

his work as a surgeon and past president of the Minnesota Medical Association. Christensen is a general surgeon at the Park Nicollet Clinic in St. Louis Park and a member of the Governor's commission to promote Minnesota's health care resources. He has served on the MMA Board of Trustees since 1982 and has been an MMA delegate to the American Medical Association. In addition, he is a fellow with the American College of Surgeons.

Mercy & Unity Hospitals Awards

Mercy & Unity hospitals have honored two physicians for outstanding service to the medical community, the hospitals, and to their local community. **Daryl J. Batalden, M.D.**, a general surgeon, received the William J. Carr Physician Recognition Award. He is the only physician to have been elected as chief of staff at both Unity and Mercy hospitals. In addition to his other medical contributions, he has served as health officer for the city of Dayton.

William N. Kinney, M.D., a radiologist, received the Richard C. Travis Physician Leadership Award. In addition to serving as chief of staff at Mercy Hospital, he has been active in the community. Among other work, he has volunteered at the Red Lake Indian Reservation clinic in northern Minnesota.

'U' Medical Foundation President

The University of Minnesota has selected a Penn State fund-raising executive to head the Minnesota Medical Foundation. **Brad Choate**, associate vice president for development and alumni relations at Penn State, will start as president and chief executive of the foundation April 8. The Minnesota

Medical Foundation solicits private contributions to support the university's medical education and research.

Under Choate since 1990, Penn State's gift revenue increased 33 percent to almost \$83 million, and the number of donors increased 15 percent.

Choate will succeed **David Teslow**, who has led the foundation's fund-raising since 1984.

Orthopaedic Academy Board

Richard F. Kyle, M.D., has been appointed to the American Academy of Orthopaedic Surgeons board of directors. He is chair of the Department of Orthopaedic Surgery and medical director of the biomechanics laboratory at Hennepin County Medical Center. He also chairs the Council of Musculoskeletal Specialty Societies and is a founding member of the Orthopaedic Trauma Association.

Children's Health Care Director

The Teen-Age Medical Service of Children's Health Care has named **Marshall Shragg** its new director. Previously, Shragg served as director of planning and community relations and assistant administrator of Pilot City Health Center. He has a master's degree in public health administration from the University of Minnesota.

The Teen-Age Medical Service addresses teens' emotional, social, and medical issues. A team of health experts works together to address the needs of adolescents and their families.

Shragg replaces **Elizabeth Myhre**, who was director of TAMS for the last 10 years. She now directs community health and preventive medicine for Children's Health Care.

continued

Places

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Mayo Inherits \$127.9 Million Estate

Texas entrepreneur and Mayo patient Barbara Woodward Lips willed her entire estate, valued at approximately \$127.9 million, to

the Mayo Foundation. Lips, who died about one year ago at her San Antonio home, had been a Mayo patient for more than 40 years. The gift is Mayo's largest in history, and it ranks among the three largest ever to any American

educational institution. It represents most of the \$199 million in donations the foundation received in 1995.

Lips requested that the money be invested and the interest and dividends it generates be used to fund patient care, medical research, and education, according to David Lawrence, chair of Mayo's Development Department.

Lips and her husband, Charles, who died in 1970, had interests in oil, gas, and ranching. They had no children.

HealthEast Renames Pain Clinic

The Minnesota Pain Center is now called the HealthEast Pain Clinic to identify it as a HealthEast clinic. Located at HealthEast Bethesda Lutheran Hospital and Rehabilitation Center, the Pain Clinic treats such problems as low back pain, cancer pain, reflex sympathetic dystrophy, and neuropathies.

Socioeconomics

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After \$23.5 Million Loss, 'U' Med School Considers Physician Pay Cut

Facing a loss of about \$23.5 million after the first half of the current fiscal year, the University of Minnesota Medical School is considering cutting physicians' base pay, according to Medical School Dean Frank Cerra, M.D. He attributed the loss to lower income from patient care. As a result, the school's reserves dropped to \$8 million, according to a Twin Cities *Star Tribune* article.

Cerra said the university is not set on cutting pay; other possibilities include increasing tuition and seeking grants from private industry. He said he hopes faculty will suggest other solutions to avoid possible layoffs.

The pay cut proposal would only affect physicians' base pay, not pay from their private practices. More pay would come in the form of bonuses and merit pay, allowing the university to reward physicians for exceptional work.



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According to the *Star Tribune* article, current base salaries are \$69,500 a year for practicing physicians and \$76,600 for scientists who hold the rank of professor; \$53,000 for practicing physicians and \$52,700 for scientists who are associate professors; and \$44,500 for practicing physicians and \$46,500 for scientists who are assistant professors.

Airport Medical Clinic Joins Park Nicollet

Airport Medical Clinic has integrated its services with Park Nicollet Clinic and assumed the new name Park Nicollet Clinic HealthSystem Minnesota—Airport Clinic. Its seven physicians are now part of Park Nicollet's Occupational Medicine Department, almost doubling its staff to 15.

Airport Clinic provides occupational medicine services to more than 600 corporate clients in the Twin Cities metro area, including Northwest Airlines, United Postal Services, Coca-Cola, Pepsi, and Super Valu. Its staff of 63 serves approximately 30,000 patients each year.

RiverPath Announces New Health Plan Options

RiverPath Community Health Network is offering two new health plan options intended to make health benefits affordable for south-central Minnesota employers. RiverPath is a joint venture between Mankato Clinic and Blue Cross and Blue Shield of Minnesota.

The new health plans have a primary care focus with point-of-service benefits. One plan has a range of deductible options, while the other has a copayment schedule.


Law & Policy

Wisconsin Lab Gets Maximum Fine for Misreading Pap Smears

A judge has fined Wisconsin's Chem-Bio Corp. the maximum allowed for reckless homicide—

\$20,000—for misreading the Pap smears of two women years before they died of cervical cancer. The ruling sets the precedent for cases involving misread Pap smears, said District Attorney E. Michael McCann, who filed the charges

about a year ago. Chem-Bio Corp., of Oak Creek, Wisconsin, pleaded no contest to charges of homicide by reckless conduct in the death of Dolores Geary, 39, and second-degree reckless homicide in the death of



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Karin Smith, 29. The lab reported that the women's Pap smears were normal, and later said that Smith's biopsies were normal. At the inquest, experts said signs of cancer were obvious. All tests were handled by the same technologist, June Fricano.

Circuit Judge David Hansher, who made the ruling, described the maximum fine as "absolutely inadequate" and called on legislators to set tougher penalties.

Medical Research

Obese Women Face Greater Pregnancy Risks

Obese women are twice as likely as normal-weight women to give birth to infants requiring extended or intensive care and about three times as likely to give birth by

cesarean section, according to a St. Paul-Ramsey Medical Center study published in the March *Obstetrics and Gynecology*.

The researchers say obese women should not diet while pregnant because women who don't gain weight during pregnancy tend to have low-birthweight babies. In addition, avoiding weight gain did not reduce the risk of complications such as diabetes and high blood pressure. Even women more than 100 pounds overweight should gain an average of 15 to 25 pounds during pregnancy, says the report.

The study compared 683 obese women (at least 50 percent over normal weight) and 660 normal-weight pregnant women who gave birth at St. Paul-Ramsey between 1977 and 1993. About 11 percent of the obese women gained no weight or lost weight during pregnancy, compared with only 0.1 percent of the normal-weight women. About 20 percent of the obese women's infants required extended or intensive care, compared with 10 percent of infants born to normal-weight women.

About 20 percent of the obese women delivered by cesarean section, compared with 10 percent of the normal-weight women. C-sections were even more common among obese women who either lost weight or stayed the same; 31 percent of these women had C-sections.

Seventeen percent of the obese women developed diabetes, compared with 3 percent of the non-obese women.

Study Detects Early Signs of Alzheimer's

Researchers studying the incidence of Alzheimer's disease among a group of nuns were able to predict with 90 percent accuracy who would develop Alzheimer's later in life merely by analyzing the writing styles of the nuns when they were young. According to the study, published in the February 21 *Journal of the American Medical Association*, nuns whose sentences

were grammatically complex and packed with ideas when the women were in their 20s remained sharp into their 80s. Nuns who used simple sentences and simple grammatical constructions tended to be demented by their 80s.

The study began in Mankato a decade ago with about 100 nuns at the School Sisters of Notre Dame and later included more than 500 other nuns from around the country. The 93 included in this study were born before 1917. Four years after they entered the convent, they were asked to write brief autobiographies. Now in their 80s, almost a third have developed Alzheimer's (similar to the incidence in the general population).

The researchers originally expected to find that the nuns' level of education would predict who developed Alzheimer's, based on a theory that advanced education and an active mind protect against the disease. However, in this study group, education offered no protection; instead, researchers suggest that Alzheimer's may begin at a young age and then manifest itself as dementia later in life.

Smokers Deny Habit's Effects on Their Asthmatic Children

A Minnesota study highlights the difficulty in educating parents who smoke about the habit's dangers to their asthmatic children. For one, parents who smoke appear to be less likely than nonsmoking parents to attend educational sessions to help control their children's asthma, according to study author and researcher Lloyd Fish, M.D., who at the time of the study was head of the allergy and dermatology department at HealthPartners. The study is published in the February *Journal of Public Health*.

In the study, which recruited parents and their asthmatic children to attend educational sessions, 17 percent of smoking parents who signed up denied on follow-up questionnaires that their children have asthma, even though medical records showed the children had

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been treated for asthma. Only 9 percent of nonsmoking parents denied their children have asthma.

The average absentee rate during the four sessions was 33 percent. However, it dropped to 24 percent for nonsmoking parents and increased to 42 percent in families with one smoking parent and 78 percent in families with two or more smokers. Attendance dropped most for smoking parents during sessions that focused on the harmful effects of smoking.

Fish and his colleagues at the Institute for Health Care Research in Palo Alto, California, used HealthPartners' computer records to identify 605 Twin Cities children with a medical history of asthma. They invited parents of the children to participate in the Wee Wheezers program, which included four educational sessions offered on 23 different occasions.

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A P R I L 1 9 9 6

Apr. 11-12 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Apr. 12 **ENT for Primary Care Physicians** St. Paul-Ramsey Medical Center and HealthEast; St. Joseph's Hospital, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 12 **Minnesota Urological Society Spring Seminar** Minnesota Urological Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/362-3737.

Apr. 13 **Minnesota Urological Society Spring Seminar: An Update on Pelvic Floor Dysfunction, Urinary Incontinence, and Female Urology** Minnesota Urological Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Apr. 18-19 **Ob/Gyn Update** St. Paul-Ramsey Medical Center; Holiday Inn East, St. Paul, MN. CONTACT: Bonnie Young, CME-Ramsey, 640 Jackson Street, St. Paul, MN 55101; 612/221-3992.

Apr. 19-20 **Adolescent Health Issues in Primary Care** Children's Health Care; Madden's Resort on Gull Lake, Brainerd, MN. CONTACT: Kathy Ingerson, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/813-5884.

Apr. 19-20 **Minnesota Orthopaedic Society 12th Annual Meeting** Minnesota Orthopaedic Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Apr. 25-26 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

Apr. 26 **Twelfth Annual Duluth Heart Conference** Duluth Clinic; Duluth Entertainment Convention Center, Duluth,

MN. CONTACT: Rockie Odberg, 400 East Third Street, Fifth Avenue Building, Duluth, MN 55805; 218/725-3838.

Apr. 26-27 **Advances in Polycystic Ovary Disease** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 26-27 **Annual Meeting—Minnesota Chapter of the American Academy of Pediatrics** Minnesota Chapter of the American Academy of Pediatrics; Mall of America, Bloomington, MN. CONTACT: Julie Pierce, 1847 131st Lane NW, Minneapolis, MN 55448; 612/757-7805.

M A Y 1 9 9 6

May 3 **MSS Spring Scientific Conference** Minnesota Surgical Society; Mayo Clinic, Rochester, MN. CONTACT: Jennifer Nelson, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/362-3736.

May 4 **Minnesota Society of Pathologists Spring Seminar: A Multidisciplinary Approach to Breast Cancer** Minnesota Society of Pathologists; HMC, Minneapolis, MN. CONTACT: Jennifer Stendahl, MSP, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

May 17-18 **Allina Pregnancy Care Initiative** Allina Health System; Radisson South, Bloomington, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

May 17-18 **Using Computers to Help Manage Clinical Information** American College of Physicians and Allina Health System; Earle Brown Continuing Education Center, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

May 30-June 1 **Management Strategies in Hematological Oncology** Mayo Medical Laboratories; Lake Louise, Alberta, Canada. CONTACT: Julie McAdams, Mayo Medical Laboratories, Hilton 360, Rochester, MN 55905; 800/533-1710.

J U N E 1 9 9 6

June 12-15 **Sixtieth Annual Course on Advances in Trauma and Critical Care Surgery** Department of Surgery, University of Minnesota Medical School; University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

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Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

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Mora, Minnesota: Aggressive, young, seven-physician family practice group seeks to add one or two physicians. Mora is a friendly community located one hour north of Minneapolis/St. Paul. There is abundant outdoor recreation in the area, including Mille Lacs Lake. The town is host to the Vasaloppet Ski Race, a half-marathon, canoe race, and bike race. If you are interested in this practice opportunity, and you should be, please contact Peter J. Donner, M.D., Mora Medical Center, Ltd., Mora, MN 55051; 612/679-1318 (wk); 612/679-1981 (hm). (11/92-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

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Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine (oncology, pulmonology, and nephrology), family practice, ophthalmology, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (2/96-R)

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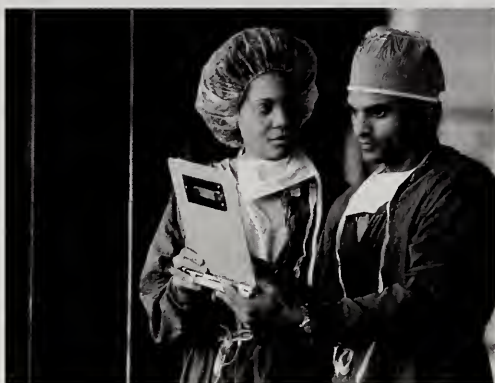
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Considering the Upper Midwest? Contact Jerry Hess, Physician Services, 3600 West 80th Street, Suite 550, Minneapolis, MN 55431; 612/896-3492. Fax: 612/896-3425. 3-6/96

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Minnesota Medicine

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COVER

As patient diversity grows, Minnesota physicians, like Kathie Culhane-Pera (center), are making sensitivity to cultural differences a hallmark of their practices.

Cover photo by Kevin White.

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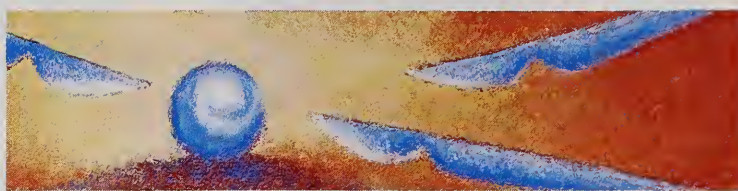
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Iron Deficiency or Thalassemia?

Editor's Note: We are introducing a new feature to Minnesota Medicine that will have practical applications. We call this occasional column "Pearls and Pointers." If you feel these tips are useful, we invite you to submit your own tricks, gimmicks, clinical findings, and original technical or clinical ideas to help make life easier for those of us in the trenches.

Clinical evaluation of microcytosis can be more complicated when the patient is from an ethnic group in which thalassemia is common.

This is particularly true for Minnesotans of Southeast-Asian descent, since the prevalence of hemoglobinopathies in this group may be as high as 20 percent to 25 percent. The differentiation of alpha or beta thalassemia from early iron deficiency in such patients may be impossible on clinical grounds alone. While additional studies such as hemoglobin electrophoresis and ferritin levels will usually resolve this question, most of these patients can be correctly and easily classified using two red cell indices usually included in the routine complete blood count. When the

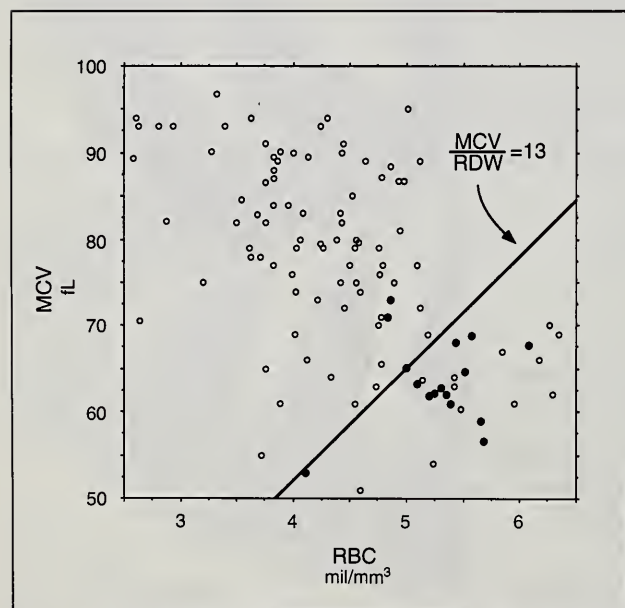
ratio of the mean corpuscular volume to the red cell count (MCV/RBC) exceeds 13 in a mildly anemic patient, iron deficiency is usually the culprit; when this ratio is 13 or less, thalassemia is usually present. This useful rule of thumb is based on the compensatory increase in red cells in patients with

microcytosis due to thalassemia but not iron deficiency.

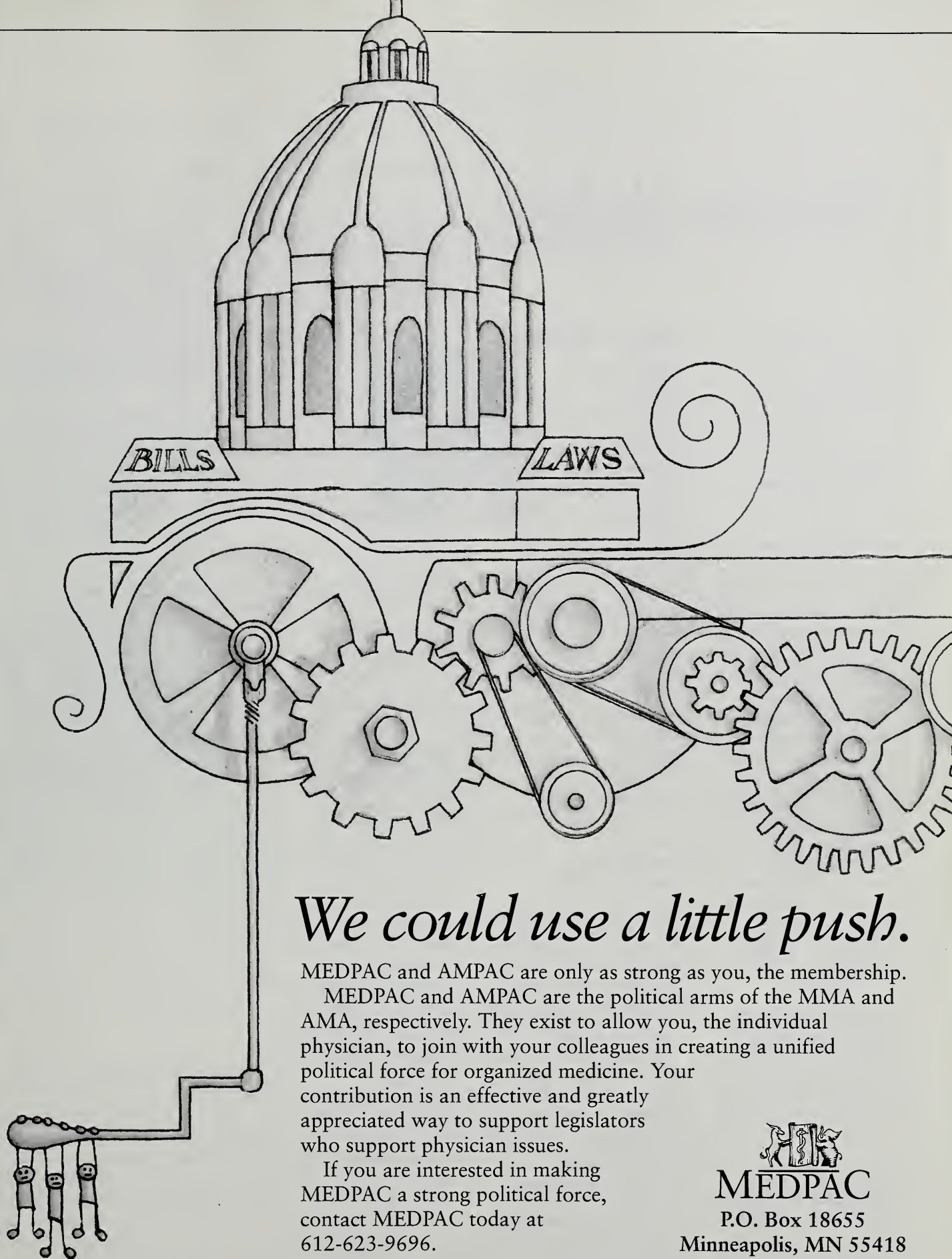
Although a variety of other formulas using red cell indices to detect thalassemia have been proposed, the MCV/RBC ratio has perhaps the best balance of accuracy and simplicity. In our experience (see figure) the ratio classifies patients correctly about 90 percent of the time. Although the figure relates to beta thalassemia minor, the MCV/RBC ratio appears to identify patients with alpha thalassemia minor as well, a hemoglobinopathy seen in many different ethnic groups. Other hemoglobinopathies, including hemoglobins S, C, and E, will usually have a ratio over 13, as seen in patients without iron deficiency.

*Submitted by Peter Benson, M.D.,
a pathologist at North Pathology
Associates in Robbinsdale,
Minnesota.*

*Send your "Pearls & Pointers" to
Editor, Minnesota Medicine, 3433
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Figure—Patients with (●) and without (○) beta thalassemia minor.



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Charles R. Meyer, M.D.

*Give me your tired, your poor,
Your huddled masses yearning to
breathe free,
The wretched refuse of your
teeming shore.
Send these, the homeless, tempest-
tost to me.
I lift my lamp beside the golden
door!*

—last stanza, "The New Colossus,"
by Emma Lazarus,
inscribed on the Statue of Liberty



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brings foreign ideas
about health that
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delivery and doctor-
patient interaction."

The United States was forged as a melting pot. From colonies founded by aristocrats and felons, our diversity has exploded over two centuries. And at times the change was a true explosion, as fear-based isolationism clashed with the ideal of a free refuge. The story continues today with moves to cap immigration and struggles to educate children of disparate backgrounds. Miami, Los Angeles, and the mother of melting pots, New York City, have faced these struggles for decades. But recently, even Minnesota has seen its monotonously homogeneous population become a collage of many colors. It isn't all Lake Wobegone anymore.

Medicine is not immune to the difficulties of meeting diverse needs. Our panoply of patients has proliferated. The influx of this cultural melange brings foreign ideas about health that challenge medical care delivery and doctor-patient interaction. This month's *Minnesota Medicine* examines health care for the "new" Minnesota.

Our articles suggest that our burgeoning cultural diversity presents four main challenges. The first is clinical. Different ethnic and racial groups have distinctive disease problems, which medicine has to fath-

om—for example, the higher risk of hypertension in African Americans, the threat of TB in immigrants from developing countries, and the greater incidence of diabetes mellitus in Chippewa and other Native American populations (see related article by Rith-Najarian et al., page 21). Unless clinicians and researchers are open to possible disease variations in "boat people," they will miss the boat and patient care will suffer.

Communication is the second challenge. Taking a history through an interpreter is a model for this. But language barriers eclipse the mere comprehension of words. Words carry different baggage for different people from different cultures. Try explaining tumor in 10 different languages. Overcoming fear and suspicion is the precondition to commu-

nication. If your patients distrust a male doctor or fear that a Pap smear will breach their virginity, all the talk in the world will be pointless. Even more fundamental is the ability to start talking. It's difficult to initiate communication with patients who don't have phones (see related article by Tosomeen et al., page 46).

The third challenge, ethics, is described by Karen Gervais (page 49). How much should medical practitioners accommodate or adapt to a patient's preexisting concepts of disease in order to provide treatment? Most Minnesota physicians are proud products of the Western scientific method with a dogma about disease causation and therapeutic rationale that has little room for the use of a shaman or medicine man. We need to look for common concepts that allow us to bring our diverse patients the care we think they need, while acknowledging that we likely don't carry the only "truth."

The final challenge, trust, is the core. Basically, the challenge of multicultural Minnesota is not so different from the challenge that confronts the practicing physician each day. Every time a doctor walks through the exam room door, he or she faces the challenge of establishing trust. Without it, all the pills in Walgreens and all the surgery of Cooley are meaningless. Believing patients get well.

Medicine is a lot like the Statue of Liberty with her beckoning torch. We have to be all-welcoming to all comers, and we have to show them the light of understanding disease and health. Medicine needs to lift a lamp to the golden door of health care in this state and light the way for all Minnesotans.

MM

TRADING PLACES

Personal experience in foreign lands has helped this cross-cultural health pioneer identify with and care for her diverse patients here in the Twin Cities.

By Douglas Clement

Photo by Bruce Baird

In 1963, when her family moved to France for a year, Kathie Culhane-Pera approached the adventure with all the brash confidence of a bright 9-year-old. "I was constantly telling my mother, 'I know that. I know that,'" she recalls. "But when we got off the boat and took a train to Paris, I decided right then and there that there was no way I was going to survive in this country. I couldn't eat the food. I couldn't understand the language. I couldn't even go to the bathroom correctly in their squatting bathrooms on the train. I just knew that this was going to be it. And I resolved myself, 'I'm just going to die in this country.'"

At a young age, Culhane-Pera understood the discomfort of being adrift in a foreign culture. That early experience now serves her well in her practice at the Department of Family and Community Medicine at St. Paul-Ramsey Medical Center, where, since September 1994, she has been director of Cross-Cultural and International Family Medicine. At St. Paul-Ramsey and as staff physician at West Side Community Health Center in St. Paul, Culhane-Pera has seen many patients who are foreign-born or from diverse cultures: Hmong, Latinos, Vietnamese, Africans, and Russians, for example.

Such patients endure not only the distress associated with their illnesses, but also the confusion of entering a medical world where the concept of disease and healing often conflicts with their own. "Culture is an extremely important influence on people's understanding of the body," says Culhane-Pera. "Illness, treatment, perspective of life and death, meaning of suffering. All that doesn't go away just because you can put a medical label on [a disease]."

A 1975 graduate of Carleton College, Culhane-Pera worked as a respiratory therapist in Gary, Indiana, and Marquette, Michigan, for four years before entering medical school at Michigan State University. Medical anthropology,



"Culture is an extremely important influence on people's understanding of the body."

—Kathie Culhane-Pera, M.D.

their traditional life was like." Her curiosity stemmed from quandaries presented in her work with Hmong patients. "Things would happen in the hospital or the clinic that we wouldn't understand. 'What are they thinking? I don't get this. It's so clear what the best choice is, yet they're choosing what to me is so clearly not the best choice. I don't understand.'" These questions led to her master's thesis, "Analysis of Cultural Beliefs and Power Dynamics in Disagreements About Health Care of Hmong Children."

She and Tim thought initially of visiting Thailand for a few months, then decided to stay for a year. They ended up making Thailand their home for three and a half years. Culhane-Pera wanted to push beyond the easy comfort of short-term tourism to experience the cycles of wrenching discomfort and profound exhilaration that are part of immersion in a foreign culture. "People the world over who are minorities—who are in a majority culture where they don't fit—may not have the luxury or the opportunity to go 'home,'" says Culhane-Pera. "I decided I had to stay there and feel the discrimination ... stay there and feel the differentness."

While in Thailand, Culhane-Pera became conversant in both White Hmong and Central Thai. She taught in the Department of Family Medicine at Chiang Mai University and conducted fieldwork in a Hmong village. She also became a mother. Twice.

After trying several years to have children, and going through a fertility work-up, she and Tim decided to adopt Sam, a baby boy from Lampang, Thailand. Then, "about nine months after we knew that Sam was going to be our child, Megan was born," says Culhane-Pera.

It is a mark of Culhane-Pera's openness to intercultural experience that, as part of her fertility work-up, she consulted Hmong healers. An herbalist provided traditional medicine and massage, while a shaman performed what Culhane-Pera calls a "diagnostic ceremo-

not biochemistry, quickened her blood, so she chose the University of Minnesota Family Practice Residency at Bethesda Lutheran Hospital in St. Paul, largely because a high proportion of its patients were Hmong. She knew little about the Hmong, but she knew she wanted a cross-cultural experience in medicine.

Donald Asp, M.D., director of Bethesda's residency program from 1970 to 1995, remembers Culhane-Pera vividly. "She was an extraordinary resident," he says. "Even from the beginning, she showed a high degree of motivation and was a particularly caring person. A good scientist, a good doctor, and clearly a pioneer in cross-cultural health."

After completing her residency, a two-year fellowship, and a master's degree in anthropology at the University of Minnesota, Culhane-Pera and her husband, Tim, left for Thailand. She wanted to understand where the Hmong people came from, "to know what



What's wrong with
this picture?

Whoever declared that art imitates

the screen of a computer as they are

of disease transmission in livestock

life obviously wasn't standing in front

behind the wheel of a combine.

and the use of antibiotics and medi-

of American Gothic. Today's farmers

Managing the growing complexities of

cines. These advanced techniques

are hardly the simple folk portrayed in


today's farm requires skills as diverse

also make Minnesota's hog and cattle

the famous painting.

as investing in hog futures and repair-

farms significantly more efficient and

 Satellite global tracking systems are one example of where technology is leading farming.

ing field equipment.

environmentally friendlier.

In fact, producing a safe and abun-

Technology has helped Minnesota

Farmers have also reduced the use

dant food supply has become more

farmers double their crop yields over

of chemicals in their fields. Instead of

complicated and difficult than ever.

the past 20 years. On land the size of

as much as a gallon per acre, they use as

The stakes are much higher and the

four city residential lots, a farmer can

little as one-sixth of an ounce per acre.

competition is much stiffer.

produce enough food to feed a family of

These reductions

Today's Minnesota farmers compete

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in chemicals, anti-

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can be processed into enough building

biotics and medicines

from the United Kingdom to the

supplies to construct a new home.

result in lower over-

Ukraine. They contribute \$2 billion to

Of course, an abundant food supply is

head costs for Minnesota farmers and a

the Minnesota economy annually in

only half the challenge. Minnesota farmers

higher quality, safer food supply for you.

foreign exports alone.

invest energy and resources to improve

So while American Gothic indeed

Competing in this global market

the quality and safety of that food supply.

merits appreciation, so do Minnesota

requires lowering costs. Becoming

Techniques like multi-site livestock

farmers. Just not for the same reasons.

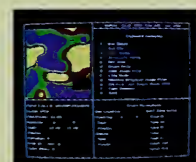
more efficient. That means staying on

production dramatically reduce the risk

top of the latest technology. Today's

 A satellite tells farmers exactly where they are in their field. An on-board computer tells them exactly what's in the soil.

farmers are as comfortable behind



Equipment then applies precisely the right amount of fertilizer and other chemicals to each individual square foot of their field.

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ny," which discovered that "the child's soul could not find the way to come down to join me. [The shaman's] helping spirits agreed to help me by guiding that spirit."

Was the shaman's work effective? "Well, I received different Hmong traditional therapies. And I got pregnant," says the doctor, somewhat elusively. "The Hmong villagers considered Megan to be their Hmong child. And indeed she is."

Now, Culhane-Pera is back home, with husband and children, teaching cross-cultural health care to others. Along with giving numerous workshops and presentations, she is a preceptor for St. Paul-Ramsey's residents at West Side Community Health Center and has helped develop a curriculum on multicultural health care.

"She's an excellent teacher," says David J. Mersy, M.D., chair of the Department of Family and Community Medicine at St. Paul-Ramsey and director of the Family Medicine Residency Program. "She has enthusiasm, knows her subject, and incorporates the feedback. Not only has she got the academic knowledge and book learning, but she's lived and experienced other cultures. It's just a perfect combination."

It is in Culhane-Pera's medical practice, though, that her skill is most keenly felt. Her patients are often of minority cultures, and she maintains an extraordinary sensitivity to their concerns. It takes time, but experience has shown that "the more time I put up front, the more family conferences I have now, the less time and money it's going to take in the long run," she says.

Like other physicians, Culhane-Pera becomes disappointed when patients reject lifesaving treatments, but she emphasizes the effectiveness of compromise to meet patient needs. She tells the story of a Hmong child who had pneumonia and possible sepsis. The father wanted to take the patient home for traditional Hmong therapy, but the pediatrician felt the child needed to stay in the hospital for frequent antibiotic treatment. Acting as a "cultural broker," Culhane-Pera helped the physician and family work out a compromise that allowed the child to go home between IV doses for traditional Hmong therapy. To make this possible, the pediatrician agreed

to change the antibiotics to create a larger time span between treatments.

"I see my role as an advocate to meet patient needs in a system that doesn't always agree with patients' [cross-cultural] values," she says.

Culhane-Pera says she can accept a patient's rejection of a standard medical treatment for cultural reasons. "What becomes hard," she says, "is when I feel the pressures of the external biomedical system to act in a certain way. The conflict I feel is that I'm going to be criticized for not insisting that someone agree with the biomedical way. That's where the pain is. I don't want to be labeled as marginal, a quack, a bad doc."

Pioneers in any field are sometimes mislabeled, and Culhane-Pera runs that risk. In responding to the expressed needs of her patients, she pushes herself outside the comfort zone of biomedical culture, encourages her colleagues to take a flexible view of today's standard of care, and argues that biomedicine will improve in the process. She points out, for example, that standard medical procedures in the early 1980s—appendectomies, supine birth posture, laying babies on their stomachs—were often opposed by the Hmong community. In the mid-1990s, Western doctors increasingly treat appendicitis with intravenous antibiotics initially, consider the squatting position for women giving birth, and routinely lay babies on their backs—all practices requested by the Hmong and now supported with scientific information.

If there is an immediate reward for such risk-taking, it is the gratitude of those she serves, and there is no doubt that Culhane-Pera is highly regarded in the Hmong community. "She understands the people and knows the language well enough to really be sensitive to the people," observes William Yang, executive director of the Hmong-American Partnership and a former patient advocate at St. Paul-Ramsey. "You know, I wish they had many more doctors like her."

MM

Douglas Clement is a free-lance writer in Minneapolis.

FEATURE STORY



STRANGERS *in a* STRANGE LAND

*Physicians are reaching beyond traditional
medicine and across cultural and social
boundaries to heal their patients.*

by Douglas Clement



V alerie Sheehan closes the door of her office to prevent interruption, steps quickly back to her desk, and continues her story. "The nurse calls me and says, 'We found a shadow on your baseline mammogram. We need you to come in for a biopsy.' "

Like all women who hear these words, Sheehan was frightened. Moreover, as an Anishinaabe Indian, Sheehan had been taught to avoid invasive procedures whenever possible. "So I decided to get another opinion," she says. She drove up to Red Lake, Minnesota, and went through a ritual with a traditional healer. "During the healing ritual, he said to me, 'Whatever is there, I'm going to take it out and put it in this bowl.' And after the ceremony was over, in the bowl I could see, it was like fat, like bacon fat. He said to me, 'This is not cancer. I think the doctors call it fibroid tissue.' "

When Sheehan returned to the Twin Cities, she canceled her biopsy, but scheduled another mammogram. "And there was no shadow! They told me that they must have made a mistake the first time. But I said 'No, you didn't make a mistake. Actually, I went to a traditional medicine man and had it healed.' And my doctor said, 'If you believe in that bullshit, you're probably going to die.' "

Sheehan looks down at her desk, recalling the mo-

ment. "I made a decision then that I would never talk to another medical doctor."

The story is dramatic, perhaps atypical. Few doctors are as openly hostile as Sheehan's. But the encounter is emblematic of an increasingly familiar phenomenon in Minnesota: cultural conflict in the provision of health care.

When physicians and patients are of different cultures, the potential for misunderstanding, conflict, and an ultimate breakdown of the physician-patient relationship is significantly heightened. Conflicts can stem from barriers as obvious as an inability to understand one another's language or as subtle as conflicting attitudes toward punctuality. Other types of cultural dissonance

include differing theories of disease and healing, misinterpretation of body language, divergent concepts of patient autonomy, conflicting beliefs about informed consent, and historical discrimination, all of which create tension in intercultural relationships.

To diminish this discord, academics, community advocates, and a growing number of health professionals say that physicians need to make significant changes in both their training and their daily interactions with patients. And since medical professionals are themselves a subculture of larger society, these changes will require nothing short of a cultural revolution.



CENTER FOR CROSS-CULTURAL HEALTH

Health care providers in Minnesota have developed niches of knowledge in coping with the demands of the state's rapidly diversifying population, but these efforts have often been isolated from one another. The Center for Cross-Cultural Health plans to coordinate these disparate efforts and draw together the resources necessary for culturally competent health care.

"We've learned repeatedly over the last several years that lack of cultural understanding has dramatic implications for the health status of an individual who is of a different culture than the provider or the system," says Beverly Propes, director of United Way-Minneapolis' Success By 6 program. "The center is going to serve as a clearinghouse to help practitioners, educators, and individuals learn

more about a culture and its traditions. The center will make those resources accessible."

With support from the Hennepin Medical Society and Foundation, North Memorial Medical Center, Abbott Northwestern Hospital, Boynton Health Service, Hennepin County Medical Center, the United Way of Minneapolis Area, the Minnesota Medical Association, Medtronic Foundation, Minnesota International Health Volunteers, and the University of Minnesota Extension Service, the center plans to open its doors in late 1996. As a clearinghouse for information, training, and research on the role of culture in health, it will serve physicians and others primarily in the Upper Midwest, but may affiliate with projects elsewhere in the United States or abroad.

For more information, call 612/624-4668.



STATE OF CHANGE

By the middle of the next century, European Americans will be a minority population in the United States, and Anglo culture will not be the standard it now seems. Even in Minnesota, one of the most homogeneous of the 50 states, cultural diversity is growing. "Even though in the 1990 census we [as a] state had one of the lowest percentages minority population, when you look at the magnitude of the change between 1980 and 1990, we then shoot to the top," notes Sonia Patten, Ph.D., an anthropologist and assistant professor in the Department of Family Practice and Community Health at the University of Minnesota. "Things are changing and changing fast in Minnesota. And physicians are a group of professionals immediately pulled into dealing with this change."

Indeed, on any given day at Hennepin County Medical Center or St. Paul-Ramsey, waiting rooms are veritable rainbow coalitions, filled with Russians, Guatemalans, Ethiopians, Dakota, Hmong, and Somalis, as well as African Americans and European Americans. Since most doctors and nurses in Minnesota are of European-American heritage, it is inevitable that patients and healers will encounter faces, languages, and cultures very different from their own.



SUBURBAN REFUGEES

Mary Chuol arrived in Anoka last August in a Jeep Wagoneer. To be precise, she was delivered in the Jeep's backseat when her mother, Elizabeth, a member of the Nuer tribe of southern Sudan, gave birth in the parking lot of Anoka's Mork Clinic. Elizabeth had come to the clinic for a scheduled ob/gyn check and waited patiently for her appointment. "The [Nuer women] are fairly stoic when they're in labor, fairly quiet," says Linda Friede, a nurse practitioner at Mork, "so the people at the front desk didn't realize how active she was."

In fact, "she was completely dilated," recalls clinic obstetrician Curt Keller, M.D. To save time, he decided to bring Elizabeth to Mercy Hospital in his own car, but her water broke as she moved from the wheelchair to the Jeep. "So I thought, no, we'd better stay here," says Keller, "but we couldn't tell her not to get in the car because she didn't understand us. The interpreter was nowhere to be found. Elizabeth climbed in the back seat of the car, pushed about two times, and had

NATIONAL EFFORTS IN CROSS-CULTURAL EDUCATION

The variety of culture-based breakdowns in the physician-patient relationship is evidently wide, as varied as the populations served; healing the relationship calls for an equally broad approach. Until recently, however, little had been done to address the problems. According to one study, only 13 of 98 U.S. medical schools responding to a 1991-92 survey offered cultural-sensitivity courses to their students, most of them optional.¹

Now, recognition of the nation's changing population has prompted efforts from coast to coast. In 1994, doctors in San Diego created the Multicultural Primary Care Medical Group, affiliated with the University of California San Diego Healthcare Network to provide "culturally appropriate" care to the city's medically underserved ethnic communities. Hispanics, Asian Americans, and African Americans make up more than one-third of San Diego County and are the fastest-growing segment of the managed care market. In the Bronx, Montefiore Medical Center's resident training program includes course work on health beliefs of other cultures. Manhattan's New York Downtown Hospital has "transcultural" workshops to help nurses serve Chinese patients.

The medical literature is also devoting more attention to cultural issues. Even the "Merck Manual" now includes a section on cross-cultural medicine.² Some texts and articles suggest lengthy interviews or analyses for physicians to use in learning more about a patient's health care beliefs before prescribing treatment.^{3,4} But the protocols tend to be long and unwieldy. One author admits that physicians will perhaps wish only "to think about the questions and mentally relate them" rather than grilling each patient.³

REFERENCES

1. Lum CK, Korenman SG. Cultural-sensitivity training in U.S. medical schools. *Acad Med* 1994;69(3):239-41.
2. Berkow R, ed. *The Merck manual of diagnosis and therapy*. Rahway, New Jersey: Merck Research Laboratories, 1992:2593-6.
3. Kune-Karrer BM, Taylor EH. Toward multiculturalism: implications for the pediatrician. *Pediatr Clin North Am* 1995;42(1):21-30.
4. Jecker NS, Carrese JA, Pearlman RA. Caring for patients in cross-cultural settings. *Hastings Cent Rep* 1995;25(1):6-14.



Rural Minnesota physicians, such as Darlene Anderson, M.D., of Worthington Specialty Clinics, are seeing an increasing number of immigrant patients.

the baby. Very quick, painless, and easy. She and the baby did just fine."

About 250 Sudanese, including Mary and Elizabeth (not their real names) have come to Anoka County since November 1994, and if their arrivals were less sudden than Mary's, their presence is no less surprising. Generally tall, thin, and extremely dark-skinned, many Nuer have long cauterized scars running horizontally across their foreheads, and other decorative scars on their cheeks, marks made during a traditional coming-of-age ceremony. They stand out in Anoka. Still, just like the Belgians and Germans before them, they come from their native land seeking a brighter future for themselves and their children.

The Sudanese present a significant challenge to the local health care system. African refugees from a decades-long civil war, they have health histories dramatically different from the average Minnesotan, but the greatest problems they and their doctors face are not medical, but cultural.

The cultural differences have had a tremendous impact in Anoka County, observes Rina McManus, director of Community Health and Environmental Services for Anoka. "It's required a lot of different adaptations to our usual health system response."

Mork Clinic's Joel Esmay, M.D., is the county's medical consultant and, as such, has taken a lead role in dealing with Sudanese refugee health concerns. Language, he says, is the primary difficulty.¹ Initially, the only interpreters available were from northern Sudan. "That created problems," says Esmay, "because they really didn't speak the [Nuer] language and, secondly, because there was a lot of animosity between the two groups." Indeed, the Nuer fled Sudan because of persecution by Arabic-speaking northern Sudanese.

Eventually, medical staff came to rely on English-speaking Nuer refugees for interpretation. But this presented its own problems: the interpreters tended to be men, and they would often answer physicians' questions directly rather than interpret for their female relatives. "I think in their culture, the men tend to speak for the family, and so they were approaching it from a different viewpoint,"

observes Esmay.

One cultural difference can be very frustrating for the more punctual physicians, says Esmay. "[The Nuer] have a completely alien time sense. For some of the Nuer, if you say the appointment is at 11 o'clock, they might show up at 1 o'clock. [Following up with patients] is a lot of work for the public health staff."

Esmay and other county professionals have dealt well with the challenges presented by Sudanese refugees, but the miscommunications and missed appointments have been time-consuming and frustrating for all involved. "There's an incredible learning curve," notes Rina McManus. "It's been a struggle."



RURAL IMMIGRANTS

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decade, towns like Willmar, Rochester, Marshall, and Worthington have become home to increasing numbers of immigrants drawn by jobs in local meat, poultry, and vegetable processing plants. Nearly one-fifth of Worthington's residents are now foreign-born, principally from Laos, Vietnam, Mexico, Ethiopia, and Sudan. They toil long hours for low wages at the Swift pork plant and Cambell's chicken processing plant.

Darlene Anderson, M.D., a family practitioner at Worthington Specialty Clinics for 15 years, has encountered all the issues Esmay describes and more. "Calling people back is a major problem," she says. "A lot of times there are multiple people living in one house and none of them speaks English. Another problem is getting people to follow through with their [tuberculosis] treatment. They often don't follow their medication. We have the health nurses running all over town to find them. We just don't understand how they look at things." And, as Esmay noted in Anoka, people of some cultures "always show up, they're on time, and others have a very relaxed attitude about their appointments," observes Anderson. "It's cultural."

In addition, Anderson notices cultural differences in handling pain.² "There are certain cultures that seem to complain about every hangnail, and then some of the Southeast Asians come in and you can't get them to complain enough to know what's going on. Our OB nurses say that all the time."

Anderson also sees positive cultural traits that seem lacking in more traditional Minnesota families. "I see a lot of [immigrant] husbands coming in with their wives to their OB visits or when there are sick children. Often both mother and father are there," she says. "It's a nice, nice family unit kind of thing. What more can you want?!"

Language problems are tougher in rural areas, where professional interpreters are non-existent. "You have them in the Cities, but not here," says Anderson. An Egyptian colleague at Worthington Specialty can sometimes communicate with Sudanese patients. The clinic's Spanish-speaking cleaning woman is often drawn in to interpret for Latin-American clients. But usually the clinic relies on friends or family members, with all attendant hazards. "Sometimes you get judgments coming through," observes Anderson. A few years ago, she was explaining to a Cambodian-Laotian

couple that their baby had Down syndrome. But the interpreter, a friend of the family, didn't understand genetics and began to tell the mother that she had damaged her child by smoking during pregnancy. Anderson tried to undo the damage but admits, "I cried after she left, because I was feeling so bad that this mother went out of here thinking that her smoking caused this Down syndrome baby."

Another area of cultural complexity lies in different concepts of patient autonomy. Anderson currently sees a Nicaraguan couple whose baby has a fetal abnormality not compatible with life. The husband understands English well, but the wife does not, and he has refused to tell her or let her be told about the baby's inevitable death. "It's not about control," says the Worthington physician. "He seems very caring. He just knows this is going to be really hard on her, and he keeps it all to himself."

Anderson believes the wife should be told and has tried without success to persuade the husband. "I said, 'If you talked to your wife about it, the two of you could share this together.' But he just says, 'I think about this all day long.' And he asks me, 'What do I have to do to bury the baby?' We all hope we won't be on shift when the time comes."

It's improbable that a European-American husband would keep his wife uninformed about such a sad fact, but Anderson is wise to respect the husband's wishes. Values surrounding death and dying and sharing sad news vary from culture to culture. Mexican Americans tend to



Dr. Darlene Anderson treats patient Josefa Zamorano at the Worthington Specialty Clinics in Worthington, Minnesota.

PHOTOGRAPH BY KEN KLOTZBACH

shield the ill from bad prognoses, as do Korean Americans.³ Navajos believe healers should not give patients negative news.⁴ These cultural differences call into question the entire Western ideal of informed consent.⁵



STRANGERS IN OUR MIDST

Patients need not be immigrants to be of different cultures than their doctors. Women increasingly search out female ob/gyns because they feel a woman physician will be more sensitive to their concerns.⁶ Gay patients may not feel understood by a heterosexual doctor. But in Minnesota, one of the largest non-majority cultures is African American, and the interactions of black patients with the largely white medical establishment are often fraught with misunderstanding, distrust, and conflict.

"I would venture to say that these days the average [African-American] person tends to believe that many physicians from the other culture just don't care, and they've become extremely distrustful," says Keyah Davis, R.N., health program officer for the Urban Coalition. "A lot of African-American people will give up their [health insurance coverage] and pay for it out of their pockets to go to an African-American physician."

Davis, herself African American, tells of her visit five

years ago to St. Paul-Ramsey Medical Center with concerns about her heart and diabetes. "A group of doctors walked in, about 10 of them, and a young, blond man approached me with some questions about my health practices at home. He asked me, 'Do you do aerobic exercise?' I said, 'Yes, I go to an African dance class twice a week.' He said, 'Is that really aerobic exercise?' And I didn't want to talk to him anymore. I said, 'If you don't know whether or not African dance is aerobic exercise, you shouldn't be talking to me.' That was my response. And I feel very strongly that, even though I was grouchy and crabby and sick, that was appropriate. I said, 'Why don't you go to the library and get a book or rent a video,' and he said, 'I don't have time.' I said, 'Then you need to exclude people from your practice if you don't have time to learn about their culture.'"

Davis says the most frequent complaint of African-American patients is that most white doctors seem to disbelieve them. "They refuse to listen if the patient, for example, is afraid the medication isn't working properly or is causing an undesirable side effect. Constantly communicating disbelief, that's the most common thing we run into."

Disbelief runs in both directions. "There's a lot of concern about experimentation" among African Americans, notes the University of Minnesota's Patten. Few of her medical students are aware of the 40-year Tuskegee study in which 412 African-American men with syphilis were left untreated by medical researchers so that symptoms could be studied. "But the Tuskegee experiment is well-known in the African-American community, all over this country," says Patten. "If you have that as part of your historical heritage, you're going to look with a somewhat jaundiced eye on the medical establishment."

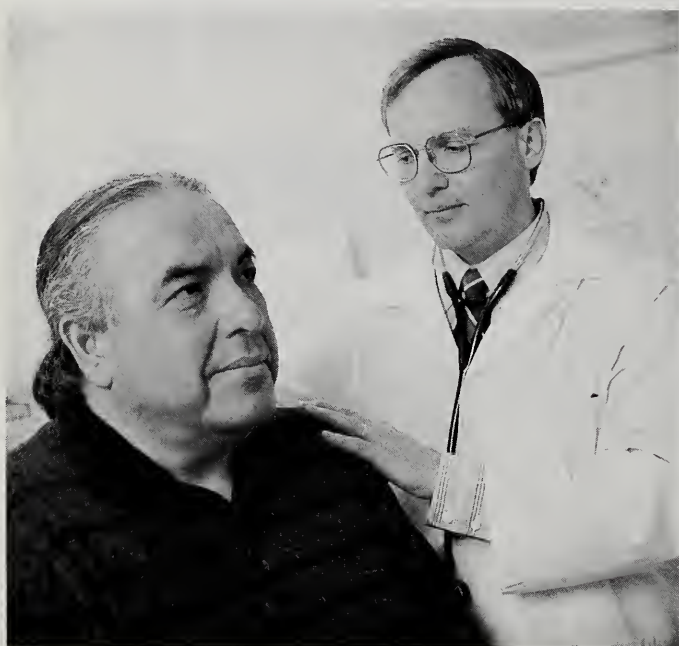


CLOSING THE GAP

Marvin Brooks, M.D., is as white bread as Minnesota gets. Born and raised in Minneapolis, of Irish-Scottish-German blood, married to an "all-Irish" wife, Brooks has practiced family medicine for 11 years at a small 1970s-style rust-orange clinic in Crystal. "Basically, I'm Caucasian, suburban Minneapolis," he admits.

But he is also one of the more "culturally competent" physicians in the state. His practice, Douglas Drive Family Physicians, owned by North Memorial Medical Center, has a surprisingly multicultural clientele. "We see patients from Russia, from Southeast Asia. It isn't

PHOTOGRAPH BY KEVIN WHITE



Marvin Brooks, M.D., treats David Larson, an American Indian from the Bde Wakan Ton Wan band, at Douglas Drive Family Physicians in Crystal.

what it used to be in terms of homogeneity." Brooks' patients include black jazz musicians and American Indian community advocates.

And in interviews, these patients speak in glowing terms of their doctor. "I feel real comfortable with Dr. Brooks," says Valerie Sheehan, the Anishinaabe woman who thought she might never again trust a physician. "I can talk to him about something I was told by my traditional healer because he won't make a mockery of it."

Brooks seems to have bridged the culture gap. "I think the most important thing is that you have to be willing to listen," says Brooks. "You have to be willing to not make judgments and to allow enough time to get to understand [your patients]. You have to respect their beliefs."

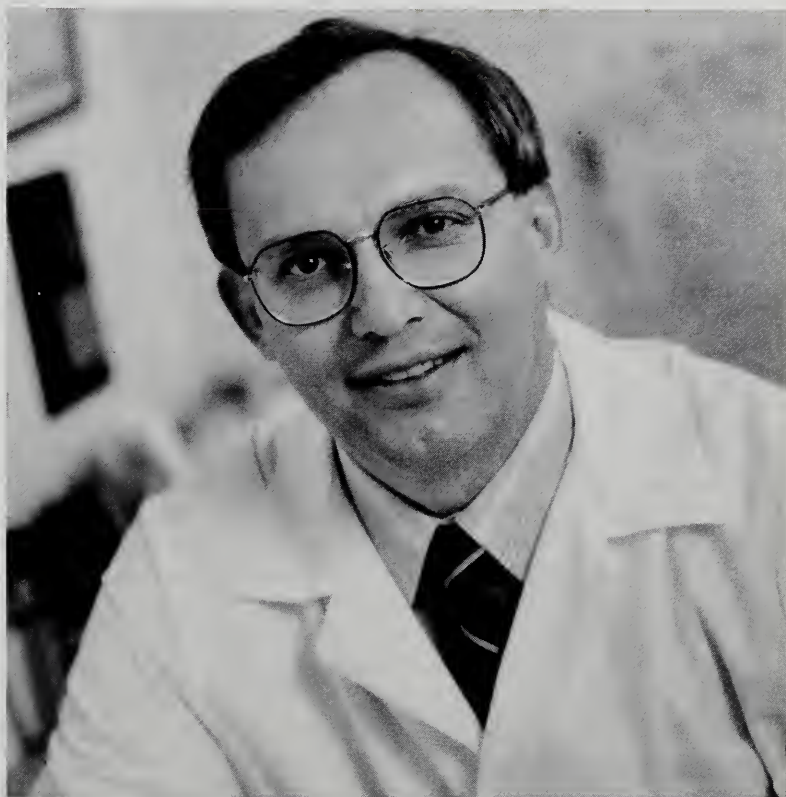
Simply put, the primary source of most culture-based conflicts in medical care is a lack of understanding and tolerance: the patient doesn't understand the doctor's perspective, and the doctor ignores or misinterprets the patient's. "Deference to views that are culturally dissonant is especially difficult in biomedical settings in which professionals and patients are unequally matched in status, power, authority, and cultural expertise," write Orr and colleagues in a 1995 *Archives of Family Medicine* article.⁷ But the onus is on the doctor.

Since physicians are in "the power position," says Sonia Patten, it is incumbent upon them to take the first steps toward understanding the patients' beliefs about their illnesses.

Brooks makes that effort. As we become more and more exposed to people from other cultures, we have to be willing to suspend our disbeliefs, he says. "If you want your patient to trust you, you have to listen to what she has to say."

Ultimately, reaching out to patients of another culture requires what any visitor to a foreign land must include with the luggage—patience, a willingness to learn and compromise, and a dose of humility. With time, an effort to understand a patient's world is likely to yield broader insights, both for the individual physician and the practice of medicine.

"The Western medical model can solve many problems, but there are limitations," observes Brooks. "I believe we're in the process today of a paradigm shift



PHOTOGRAPH BY KEVIN WHITE

Dr. Marvin Brooks, who serves a multicultural clientele at Douglas Drive Family Physicians in Crystal, says a willingness to listen and an ability to avoid prejudging are important skills in cross-cultural health care.

in the Western medical model, and one of the things that's going to push a re-examination of the model, in addition to economics, will be the change in the population—the change in who it is that we're dealing with and serving."

MM

Douglas Clement is a free-lance writer in Minneapolis.

REFERENCES

1. Woloshin S, Bickell N, Schwartz L, Gany F, Welch H. Language barriers in medicine in the United States. *JAMA* 1995;273(9):724-8.
2. Bates MS, Rankin-Hill L. Control, culture and chronic pain. *Social Studies and Medicine* 1994;39:629-45.
3. Blackhall L, Murphy S, Frank G, Michel V, Azen S. Ethnicity and attitudes toward patient autonomy. *JAMA* 1995;274(10):820-5.
4. Carrese JA, Rhodes L. Western bioethics on the Navajo Reservation: benefit or harm? *JAMA* 1995;274(10):826-9.
5. Gostin LO. Informed consent, cultural sensitivity, and respect for persons. *JAMA* 1995;274(10):844-5.
6. The male gynecologist: soon to be extinct? *Wall Street Journal* 1996 February 7: Sect. B:1.
7. Orr RD, Marshall PA, Osborn J. Cross-cultural considerations in clinical ethics consultations. *Arch Fam Med* 1995;4:161.

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4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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Screening and Diagnosis for Gestational Diabetes Mellitus Among Chippewa Women in Northern Minnesota

Stephen J. Rith-Najarian, M.D., Frederick K. Ness, M.D.,
Thomas Faulhaber, M.D., and Dorothy M. Gohdes, M.D., F.A.C.P.

ABSTRACT

We reviewed prenatal records of Chippewa women residing on two Minnesota reservations to define the incidence of gestational diabetes mellitus (GDM) and to describe the screening and diagnosis practices for GDM according to National Diabetes Data Group Criteria. Of the 554 pregnancies included in the study, six (1%) involved women with preexisting diabetes mellitus and 32 (5.8%) with GDM. In 24 (4.3%) of the pregnancies, the women were misclassified as having GDM. Women completed screening and/or testing during 450 (82%) of the pregnancies—by 32 weeks gestation for 401 (73%). This is of 548 pregnancies that could potentially have involved GDM. Women with incomplete screening and/or testing were older and of higher parity than those who completed negative screening and/or testing ($p < 0.05$). Chippewa Indian women in northern Minnesota experienced GDM at rates higher than most other U.S. populations. Screening rates for GDM were high, but some high-risk women were not screened. Programs targeting high-risk women for timely and accurate diagnosis of GDM are needed in this primary care setting.

Gestational diabetes mellitus (GDM) is a preventable cause of prenatal morbidity and mortality,^{1,2} and Minnesota public health programs have targeted its control.^{3,4} Pregnancies complicated by GDM are at increased risk for macrosomia, neonatal birth trauma, neonatal hypoglycemia, perinatal mortality, maternal birth trauma, and cesarean section.^{5,6} Recent studies have demonstrated that intensive prenatal GDM management reduces the risk for these associated adverse outcomes;^{1,2} however, timely and accurate diagnosis of diabetes in pregnancy is essential if such management is to be effective. Accordingly, the American College of Obstetricians and Gynecologists recommends screening women at high risk for GDM between 24 weeks and 28 weeks gestation and following standardized criteria for diagnosis.⁷ Moreover, the Minnesota Diabetes Control Program, a federally funded, state-based public health initiative, has defined strategies to promulgate standardized detection and management of GDM.^{3,4}

While little is known about the frequency of GDM complicating pregnancies in Minnesota, population-based studies in the United States have produced GDM prevalence estimates of 2% to 15% of pregnancies, depending on the screening practices, diagnostic criteria applied, and the population studied.⁸⁻¹³ Among the populations at highest risk for GDM are those with susceptibility to non-insulin-dependant diabetes mellitus (NIDDM).¹⁴ Native Americans residing in urban and reservation communities throughout Minnesota are known to be at high risk for NIDDM¹⁵⁻¹⁷ and probably are at high risk for GDM. This report defines the risk for GDM in two Chippewa

Indian reservations in Minnesota and examines the patterns for screening and diagnosis of GDM in the primary care settings serving these communities.

METHODS

We retrospectively reviewed outpatient records of Chippewa Indian women living on one of two reservations in northern Minnesota who gave birth between July 1990 and November 1992. We identified records from prenatal registries maintained at the two local Indian Health Service (IHS) clinics serving the respective reservations. These registries included the pregnancies of women who received prenatal care at the IHS clinic. In addition, the pregnancies of women who sought no prenatal care or who received care elsewhere were identified by clinic or field health staff and listed in the registry. We also reviewed the regional non-IHS clinic outpatient records for these latter pregnancies to confirm the pregnancy and abstract data. Because of the clinic's close ties with the community and the extensive field health staff, the number of pregnancies not listed on the registry is probably small. Excluded from the study were pregnancies of women who moved a distance of more than 50 miles from the reservation communities, miscarried or terminated at less than 20 weeks gestation, were non-Indian recipients of care, or whose outpatient records could not be located. Patients with preexisting diabetes were excluded from the analysis of GDM screening rates.

In our record review, we defined a positive screening test for GDM as a one-hour post 50-gram carbohydrate load serum glucose with a value of ≥ 140 mg/dl. We defined a case of GDM according to the criteria set

Table 1

*Clinical characteristics of Chippewa Indian women during pregnancy by diabetic status**

Diabetic status	N	Age (years)	Parity	BMI (kg/m ²) [†]
Preexisting diabetes	6	31.2 ± 6.1	2.0 ± 2.4	37.5 ± 6.2
Gestational diabetes	32	28.7 ± 4.3	2.3 ± 1.8	31.1 ± 6.7
Non-diabetic	418	23.6 ± 5.2	1.5 ± 1.6	25.4 ± 4.9
Unknown [‡]	98	24.8 ± 5.0 [§]	2.4 ± 2.1 [¶]	26.3 ± 5.1
Total	554	24.2 ± 5.3	1.7 ± 1.7	25.9 ± 5.3
Misclassified	24	28.2 ± 5.6 [§]	3.1 ± 2.6 [¶]	29.4 ± 5.2 [§]

*Expressed as mean ± standard deviation.

[†]Pre-pregnant body mass index.[‡]Incomplete screening and or testing for diabetes.[§]p<0.05, analysis of variance compared with nondiabetic.[¶]p<0.001, analysis of variance compared with nondiabetic.

forth by O'Sullivan and Mahan, in which at least two glucose values in a three-hour post 100-gram carbohydrate load oral glucose tolerance test (OGTT) are abnormal; i.e., a fasting level ≥ 105 mg/dl, a one-hour level ≥ 190 mg/dl, a two-hour level ≥ 165 mg/dl, or a three-hour level ≥ 145 mg/dl.¹⁸ Individuals were considered misclassified if their medical records indicated diagnosis of or treatment for GDM but did not meet this standardized diagnostic criterion. Preexisting diabetes mellitus was defined by National Diabetes Data Group Criteria.¹⁹ Women were considered to have completed screening and/or testing if they had a one-hour post 50-gram carbohydrate load result <140 mg/dl or if they had a three-hour OGTT. We analyzed data for prepregnancy age, parity, and body mass index according to diabetes status in pregnancy. Significant differences were determined by Analysis of Variance using EpiInfo 6.01 software.²⁰

RESULTS

Of the total 684 pregnancies recorded in the registries during the study period, we located 666 (97%) medical records for review. Of these, we excluded 112 (41 of the women moved, 36 miscarried or terminated before 20 weeks gestation, 20 were non-Indian, 11 delivered before the date of the study period, and four had no record of a pregnancy). We reviewed the remaining records—554 pregnancies in 501 women—for this study.

Preexisting diabetes mellitus defined by National Diabetes Data Group Criteria were documented in six (1%) of the 554 pregnancies, and 32 pregnancies (5.8%) met the O'Sullivan Criteria for GDM. We found 24 pregnancies to be misclassified as GDM according to criteria that included a positive screen and no further testing (nine cases), GDM diagnosed in a prior pregnancy only (eight cases), a single abnormal value on a three-hour OGTT (five cases), and an abnormal casual blood glucose (two cases). Compared with pregnancies of women who had negative screening and/or testing for GDM, the misclassified pregnancies

Table 2

Barriers to diabetes screening in pregnancy among Chippewa women who failed to complete screening and testing by 32 weeks gestation*

Probable barrier to screening and testing	N	%
Access to or utilization of care	65	44%
No prenatal care	13	
No prenatal care 24-32 weeks	12	
First visit 24-32 weeks, no follow-up	17	
Care initiated >32 weeks	23	
Screening and testing complexity	25	17%
No follow-up tests for positive screen		
Missed opportunity	57	39%
Had routine prenatal care 24-32 weeks		
Total	147	100%

*Definitions:

Screen: one-hour post 50-gram carbohydrate load serum glucose.

Test: three-hour post 100-gram carbohydrate load oral glucose tolerance test.

were characterized by women who were older, of higher parity, and heavier ($p < 0.05$) (see Table 1).

Five hundred and forty-eight of the pregnancies involved women at risk for GDM. Screening was completed during 466 of the pregnancies, leading to 121 positive results (≥ 140 mg/dl). Definitive testing was done in 95 of the pregnancies, yielding 24 cases of GDM. One other GDM case was found among eight pregnancies when testing was performed, despite screening values of less than 140 mg/dl. In 10 pregnancies, testing was performed without screening, yielding seven more cases of GDM (see figure). In total, screening and/or testing was completed during 450 of the 548 pregnancies (82%)—by 32 weeks gestation for 401 (73%). It was completed during the 24- to 28-week interval for 302 (55%) of the pregnancies. The women's mean age and parity for pregnancies with incomplete screening and/or testing were higher than for those who completed negative screening and/or testing ($p < 0.05$) (see Table 1).

In 147 pregnancies, screening and testing was incomplete at 33 weeks gestation, the critical time to initiate treatment for diabetes. Failure to screen was attributable to either limited access to care or underutilization of prenatal services in 65 (44%) of these cases. There was no prenatal care in 13 cases, care initiated after 32 weeks gestation in 23 cases, no visits between 24 and 32 weeks in 12 cases, and a first contact between 24 and 32 weeks with no follow-up care in 17 cases. An additional 25 cases (17%) with positive screens received no follow-up testing. However, in 57 pregnancies (39%), routine prenatal care was sought between 24 and 32 weeks and clinicians missed the opportunity for screening and/or testing (see Table 2).

DISCUSSION

Although there are numerous reports on the epidemiology of diabetes in pregnancy, this report is among the limited number of community-based studies on the incidence of GDM in which universal screening and standardized criteria were applied. The 5.8% incidence of GDM in Chippewa

women reported here is higher than the 2% to 3% rates reported for screened cohorts in urban, ethnically diverse populations.⁸⁻⁹ Compared with other American Indian populations, the rate is higher than rates observed among Navajo women (4.1%),¹⁰ and Tohono O'odham women (3.2%),¹¹ and is comparable with rates for Yup'ik Eskimo women (5.8%),¹² but lower than the rate among Zuni women (14.5%).¹³ However, the rate reported here for the Chippewa women is probably underestimated, since screening and testing were incomplete in 18% of pregnancies in which the mean age and parity conferred a higher risk for GDM than for women with negative screening and/or testing.⁶

The overall screening rate of 82% in this high-risk setting was similar to screening rates for GDM reported from other settings. In a study of women delivering at Mount Sinai Medical Center in New York, 81% were screened for glucose intolerance during pregnancy; however, women who did not receive prenatal care were excluded from the study.⁹ In a 1989 study, Mazze and Krogh found that of 798 women who received prenatal care from primary care physicians at one of four urban clinics, only 57% underwent screening. Moreover, 20% of high-risk women and 31% of those who produced macrosomic infants were not screened.²¹ These data support our observations that women at high risk for GDM are also at high risk for failure to be screened for GDM.

Although prenatal care was provided without direct cost to the individual patients in the communities we studied, the patient's failure to utilize the prenatal care system was the leading cause of failure to screen and/or diagnose GDM. Similar barriers

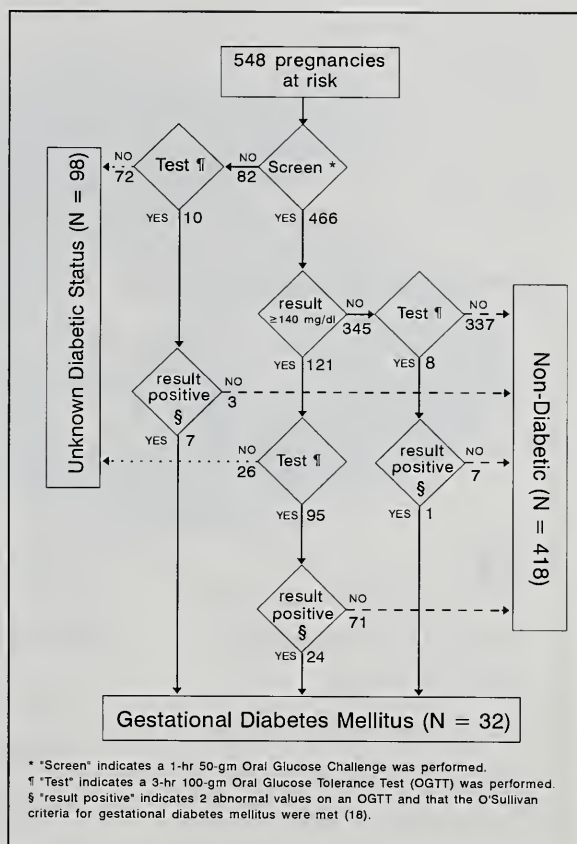


Figure 1—Patterns of screening and testing for gestational diabetes mellitus in a primary care setting serving Chippewa women.

riers to prenatal care have been described in other minority populations. In a recent national review of birth records, late initiation of prenatal care and absent prenatal care were higher among American Indians and other minorities than among Caucasians.²² Kugler and coworkers have found that poor socioeconomic status, a condition common in reservation communities,²³ is associated with low utilization of prenatal care, even when care is provided without charge.²⁴ Among diabetic women in southeastern Michigan, failure to seek preconception counseling was associated with lack of prior discussion of preconception care, prior missed clinic visits, low educational attainment, unemployment, and incomes below \$20,000.²⁵ Public health programs that assess and address socioeconomic barriers and health beliefs are essential if we are to improve access to and utilization of appropriate prenatal services.

CONCLUSION

Chippewa Indian women in north-

ern Minnesota experienced GDM at rates higher than most other U.S. populations. Screening rates for GDM were high, but some high-risk women were not screened. Programs targeting high-risk women for timely and accurate diagnosis of GDM are

needed to manage GDM appropriately and ameliorate the consequences of this treatable disease. **MM**

The opinions expressed in this manuscript are those of the authors and do not necessarily represent those of the Indian Health Service.

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REFERENCES

1. Langer O, Rodriguez DA, Xenakis EM, McFarland MB, Berkus MD, Arredondo F. Intensified versus conventional management of gestational diabetes. *Am J Obstet Gynecol* 1994;170:1036-47.
2. Langer O, Berkus M, Brustman L, et al. Rationale for insulin management in gestational diabetes mellitus. *Diabetes* 1991;40(Suppl. 2):186-90.
3. Minnesota Diabetes Steering Committee. Minnesota plan to prevent disability from diabetes. Minneapolis: Minnesota Department of Health, 1991.
4. Minnesota Diabetes Steering Committee. Diabetes and pregnancy. Minnesota Department of Health Disease Control Newsletter 1989;17:29-32.
5. Johnstone FD, Nasrat AA, Prescott, RJ. The effect of established and gestational diabetes on pregnancy outcome. *Br J Obstet Gynaecol* 1990;100:9-15.
6. Jacobson JD, Cousins L. A population-based study of maternal and perinatal outcome in patients with gestational diabetes. *Am J Obstet Gynecol* 1989;161:981-6.
7. American College of Obstetricians and Gynecologists. Diabetes and pregnancy. Technical Bulletin No. 200, 1994:5-6.
8. Coustan DR, Nelson C, Carpenter MW, et al. Maternal age and screening for gestational diabetes: a population-based study. *Obstet and Gynecol* 1989;73:557-61.
9. Berkowitz GS, Lapinski RH, Wein R, Lee D. Race/ethnicity and other risk factors for

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gestational diabetes. *Am J Epidemiol* 1992;135:965-73.

10. Sugarman JR. Prevalence of gestational diabetes in a Navajo Indian community. *West J Med* 1989;150:548-51.

11. Livingston RC, Bachman-Carter K, Frank C, Mason WB. Diabetes mellitus in Tohono O'odham pregnancies. *Diabetes Care* 1993;16 (Suppl. 1):318-21.

12. Murphy NJ, Bulkow LR, Schraer CD, Lanier AP. Prevalence of diabetes mellitus in pregnancy among Yup'ik Eskimos, 1987-88. *Diabetes Care* 1993;16(Suppl. 1):315-21.

13. Benjamin E, Winters D, Mayfield J, Gohdes D. Diabetes in pregnancy in Zuni Indian women: prevalence and subsequent development of clinical diabetes after gestational diabetes. *Diabetes Care* 1993;16:1231-6.

14. Coustan DR. Gestational diabetes. In: Harris MI, ed. *Diabetes in America*. 2nd ed. Washington, D.C.: National Institutes of Health, 1995:703-17. NIH Publication No. 95-1468.

15. Gillum RF, Gillum BS, Smith N. Cardiovascular risk factors among urban American Indians: blood pressure, serum lipids, smoking, diabetes, health knowledge, and behavior. *Am Heart J* 1984;107:765-77.

16. Gohdes D, Kaufman S, Valway S. Diabetes in American Indians: an overview. *Diabetes Care* 1993;15(Suppl. 1):239-43.

17. Rith-Najarian S, Valway S, Gohdes D. Diabetes in a northern Minnesota Chippewa tribe: incidence and prevalence of diabetes and incidence of major diabetic complications, 1986-88. *Diabetes Care* 1993;15(Suppl. 1):266-70.

18. O'Sullivan JB, Mahan CM. Criteria for the oral glucose tolerance test in pregnancy. *Diabetes* 1964;13:278-85.

19. Harris M. Classification, diagnostic criteria, and screening for diabetes. In: Harris MI, ed. *Diabetes in America*. 2nd ed. Washington, D.C.: National Institutes of Health, 1995:15-36. NIH Publication No. 95-1468.

20. Dean AG, Dean JA, Coulombier D, et al. EpiInfo, version 6: a word processing, database, and statistics program for epidemiology on microcomputers. Atlanta, Georgia: Centers for Disease Control and Prevention, 1994.

21. Mazze RS, Krogh CL. Gestational diabetes mellitus: now is the time for detection and treatment. *Mayo Clin Proc* 1992;67:995-1002.

22. Centers for Disease Control and Prevention. Prenatal care and pregnancies complicated by diabetes—U.S. reporting areas, 1989. *MMWR* 1993;42:119-22.

23. Shalala DE, Lee PR, Lincoln ME, et al. Population statistics. In: *Trends in Indian health*. Rockville, Maryland: Public Health Service, 1993:25-31.

24. Kugler JP, Yeash J, Rumbaugh PC. The impact of sociodemographic, health care system, and family function on prenatal care in a military setting. *J Fam Pract* 1993;37:143-7.

25. Janz NK, Herman WH, Becker MP, et al. Diabetes and pregnancy: factors associated with seeking pre-conception care. *Diabetes Care* 1995;18:157-65.



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Cultural Barriers to Health Care for Refugees and Immigrants

Providers' Perceptions

Patricia Ohmans, M.P.H., Craig Garrett, M.D., and Christa Treichel, Ph.D.

ABSTRACT

What are the barriers to good health care for immigrants who have come to the Minneapolis-St. Paul metropolitan area since the early 1980s? Why do immigrants often delay or avoid seeking mainstream health care services? The research described here examines these questions from the perspective of nonimmigrant health care providers in the Twin Cities.

The 24 metropolitan health care providers interviewed in our study confirmed the existence of significant barriers to health care—barriers that probably differ from those experienced by nonimmigrant patients. Refugees and immigrants from other cultures had varying culturally based reactions to Western-style, allopathic medicine—some positive and many negative. Providers and administrators must consider these barriers when serving a growing population of immigrant patients.

How does a Cambodian man who spent years in a re-education camp convey the nature of his "total body pain" to his concerned but mystified family practitioner? What should a gynecologist say to the Somali woman who denies being sexually active, yet is three months pregnant? How should an emergency department physician raise the question of organ donation to the family members of a Russian-Jewish accident victim? These are some of the questions health care providers raised in our study of barriers to health care for refugees and immigrants.

This study was undertaken in light of a demographic explosion—the leap in numbers of refugees and immigrants in the Twin Cities metropolitan area in the past 10 years. Although the exact number of immigrants currently living in Minneapolis and St. Paul is not available, certain other measures clearly demonstrate this growth. The 1990 U.S. Census notes that the Asian population in Hennepin County grew by more than 200% in the previous decade, to a total of 29,588 individuals. Concurrently, Minnesota had the highest growth rate of Hispanics in the Midwest, with 13,978 Hispanics living in Hennepin County alone in 1990.

Immigrants come to the Twin Cities from around the world: China, Tibet, Somalia, Ethiopia, Eritrea, Eastern Europe, the former Soviet Union, and Central and South America. While most immigrants to the United States first arrive in a border state, secondary migration (within the United States) to Minnesota is the highest in the country, according to the Minnesota Department of Human Services.

Demographic changes in the met-

ropolitan area are reflected in staffing and service changes at Hennepin County Medical Center (HCMC). In 1980, HCMC hired its first staff interpreter. Now HCMC has a staff of 17 foreign language interpreters and 15 interpreters who work on-call. In 1992, HCMC's interpreters had 14,542 contacts with patients; in 1995 they logged more than 100,000 patient contacts.

Caring for patients who need interpreters is costly when institutions are unprepared. For example, immigrant patients were often over-represented in emergency room admissions to HCMC, especially for nonemergency complaints, requiring expensive on-call interpreters. Recently, the staff at HCMC began to consider centralizing its foreign language clinics into one larger "umbrella" clinic, but staff members quickly realized that they do not know enough about the specific problems HCMC's immigrant patients encounter when seeking health care. In 1994, an HCMC physician, Craig Garrett, M.D., requested support from the Minneapolis Medical Research Foundation to examine these problems. The result is the study described below.

Our study asks: Why do some immigrants delay or avoid seeking mainstream health care services? What can be done to make health care more culturally compatible with the values and practices of diverse patients? Hennepin County Medical Center staff and external consultants are conducting this multiphase study, funded in 1994 through 1996 by the Minneapolis Medical Research Foundation.

The study's first phase, described in part below, consisted of interviewing providers from social services and other health care fields who work with immigrants in the Twin Cities

area. A second phase, still in progress, involves interviewing several families representing different immigrant ethnic groups to identify and understand barriers to care from the patients' perspectives. A final, synthesis phase, comparing immigrant and nonimmigrant patients, is planned for 1996-97.

METHODS

PROVIDERS

Hour-long qualitative interviews with 24 health care providers were conducted over a two-month period. Interviewees were not selected at random. Instead, we attempted to select key informants who serve the range of immigrants represented in the metropolitan area. We included individuals from various professions: eight physicians, an attorney, three health administrators, two nurses, a refugee health services coordinator, three heads of nonprofit social service or health agencies for immigrants, a health care consultant, a social worker, a psychologist, and three resettlement workers.

PROVIDER INTERVIEWS

Interviews were conducted in person and over the telephone. A semistructured interview guide was used, but respondents were encouraged to elaborate on their answers. Interviewees were assured that their responses would be confidential and would not be attributable to them, even indirectly.

Providers were asked about their professional roles and their agencies' interactions with refugees and immigrants. They were also asked to respond to a series of questions about availability of health care services, access to those services, and the cultural appropriateness of the services. Answers to the questions about cultural appropriateness are reported below.

RESULTS—CULTURAL BARRIERS TO CARE

Providers were asked to respond to a list of 10 possible barriers to care that related to cultural differences between immigrant patients and nonimmigrant providers, or between Western and non-Western medical systems.

An edited selection of responses to each cultural barrier is given below.

GENDER

Survey respondents stressed the importance of gender in traditionally sensitive areas of health care, such as obstetrical and gynecological care.

• "We always use a female interpreter for ob/gyn."

• "Any immigrant female who is a torture survivor is quite possibly also a rape victim—we never have male doctors examine female patients."

• "[Muslim] women won't let a male provider touch them. When I set female patients up for tests, I have to make sure the lab worker is female."

• "Muslim men sometimes won't even let me examine their genitalia. I usually ask them, 'Would you feel more comfortable if a man examined you?'"

• "Even when taking a sexual history with a Muslim patient, if I ask, 'Are you sexually active?' they'll say no. I've gotten 'no' answers from women who were pregnant. So I ask, 'Are you married?' instead."

CLASS

Respondents emphasized the tie between patients' social status and educational attainment, which in turn affects health behavior. Providers said they are aware that their patients' social status may have changed markedly from what it was in their home countries and that some class distinctions that were meaningful elsewhere no longer pertain in the United States and vice versa.

• "Immigrants from rural areas or those with less education are more likely to avoid or delay seeking care."

• "There is a perception among some Russians that [U.S.] county hospitals are for poor people, that the population is too mixed."

• "Many immigrants are dealing with severe changes in class or social status due to immigration or exile."

• "We should be particularly careful with health education; providers should not assume that refugee status equals poverty equals lack of education."

• "We have people who call up

and ask, 'I'm a Ukrainian; can I still come to your clinic?' Or the older population might start discussing who was in the camps, who was a guard in the camps."

• "We treat Ethiopian, Somali, and Sudanese immigrants in the homeless shelter. They don't seem to feel that being in a shelter makes them downwardly mobile, the way Americans do."

AGE

Survey respondents were divided about the effect of age on acceptance of new health care practices.

• "Younger refugees have less fear of the system."

• "Sometimes an older patient has more self-confidence."

• "The young doctor is suspect."

• "My patients are more accustomed to the older provider, one who doesn't smile."

INTRUSIVE OR INVASIVE PROCEDURES

Respondents' comments revealed that practices involving removal of blood or tissue or invasive procedures are difficult for many immigrant patients. Providers surveyed said they have made efforts to accommodate their patients' cultural preferences—at least those they are aware of.

• "[Most Hmong patients resist] any procedure that physically changes a person, or the removal of any part of the body, even something like a tumor that should be removed."

• "There's a lot of anxiety about taking blood. I can usually negotiate about quantity (take less), timing (take less often), place (do a fingerstick instead of a vein), and influence (offer a vitamin to build the blood back up)."

• "We've stopped doing quite so many pelvises, and we made a videotape to explain prenatal care."

• "Those who practice Buddhism believe the head is the most sacred part of the body. Whenever I'm examining a patient and am going to touch their head, I say 'excuse me.'"

SYSTEMS DIFFERENCES

Respondents characterized Western medicine as highly mechanistic, at least in comparison with non-Western systems, which recognize spiritu-

al or metaphysical causes of ill health. Such systems differences put barriers between providers and immigrant patients. "This is a major, major problem," said one provider, who was echoed by many others critical of limitations in Western-style medicine.

- "Many cultures recognize three causes of disease: metaphysical, supernatural, and natural/physical. We only recognize one, and that puts us at a disadvantage."

- "We're so concerned about the etiology of disease. They're more concerned about how it makes them feel, and are more impressed at pain relief than tumor removal."

- "Our system seems so invasive. All that palpating, percussing, blood drawing. Traditional healers do a hands-on assessment of their patients. There's a big difference."

MISTRUST OF HEALTH CARE INSTITUTIONS

Providers reported that many immigrant patients mistrust their health care institutions or services. They

have varying reasons for doing so, depending on their country of origin. Latinos, for example, may have fears related to the status of their U.S. residency. Immigrant Russians sometimes associate health care with political repression.

- "Even [Mexican Americans] who are legal have a fear of their legal status being taken away from them somehow."

- "Psychiatry took a beating in the Soviet Union because of its relationship to the government. Political dissidents filled the psychiatric hospitals."

NON-RECOGNITION OF MEDICAL NEED BY PATIENT OR PROVIDER

Respondents acknowledged that illnesses recognized by their patients were sometimes invisible to them and vice versa.

- "I'm familiar with a couple of cases of Southeast Asian men who said they couldn't walk, but nothing could be found that was wrong with them. I believe it was mental health related."

- "A Cambodian woman may say, 'I've had a lot of Pol Pot syndrome,' which means nightmares, insomnia, night sweats."

- "In many cultures, gambling is not recognized as an addiction or even a problem, the way it is here."

- "Chemical dependency is a taboo question with Russian immigrants. None of our clients would think that getting drunk at a birthday party is a crime."

- "Some patients may have a religiously based belief that suffering is a necessary or inevitable part of life and may not be as interested in stopping disease."

LACK OF ACKNOWLEDGMENT OF FAMILY SYSTEMS

Respondents said they were able to work with families at times, but had some reservations about making major changes in their practices to accommodate members of an immigrant patient's extended family who felt they should have a say in the patient's care.

- "People won't avoid going to

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the doctor because of family systems, but it will come up," said one respondent, describing the impact of this commonly cited cultural factor.

- "Individuality is a Western concept. If a [Hmong] child has a brain tumor, the family elders will decide the course of treatment."

- "Providers don't always see that things won't happen if the head of the household doesn't want them to happen. A very common example is when a woman no longer wants to be pregnant and the family says, 'It's your duty.'"

- "In a Latino health care system, it is very common that a patient with a terminal illness will not be told about it, but perhaps the eldest female in the family will be told."

- "Hospitals can be more flexible, allowing culturally familiar foods to be brought in, for example."

- "Allowing only one or two people in an ICU is hard in a culture where everyone would normally be around the bedside."

- "We try to do family conferences, but they are time-consuming

and you don't always succeed with them. My experience is that the clan elder may be adept at advising about things such as purchasing a pig, but that they themselves will acknowledge they don't know Western medicine."

- "In mental health, family systems are obviously important, but I'm not sure how to work in a complicated family system, with an interpreter, to boot."

PRACTITIONER PERCEIVED AS ALIEN OR DISTANT

A number of respondents said they have found that culturally appropriate bedside manner varies with the culture and the patient.

- "Hmong patients are especially upset by expressions of anger, when Western doctors seem irritated or frustrated."

- "The great fear is that doctors are learning on Hmong patients, or that they are taking blood or body parts to sell or give away. A listening, kind, respectful, slow manner will offset some of those fears."

- "Practitioners often dress too

casually [for Russian patients] and don't take illness seriously enough. They should act more deliberate, and not seek the patient's opinion at every step."

STIGMA OR SHAME OVER CERTAIN CONDITIONS

Respondents noted that many conditions are stigmatized among immigrant patients.

- "STDs are stigmatized."
- "Lepers are shunned by their communities."

- "In Southeast Asian cultures, illegitimate pregnancy can be stigmatized, especially if there is a rape."

- "For a newly arrived immigrant [Latino] woman, pregnancy might be shameful. Perhaps they came to the United States because they're pregnant and they didn't want their family to know."

- "I don't know for sure, but certain illnesses do have special meanings for Somali patients. Hemorrhoids are a terrible thing that need surgical removal, apparently."

continued

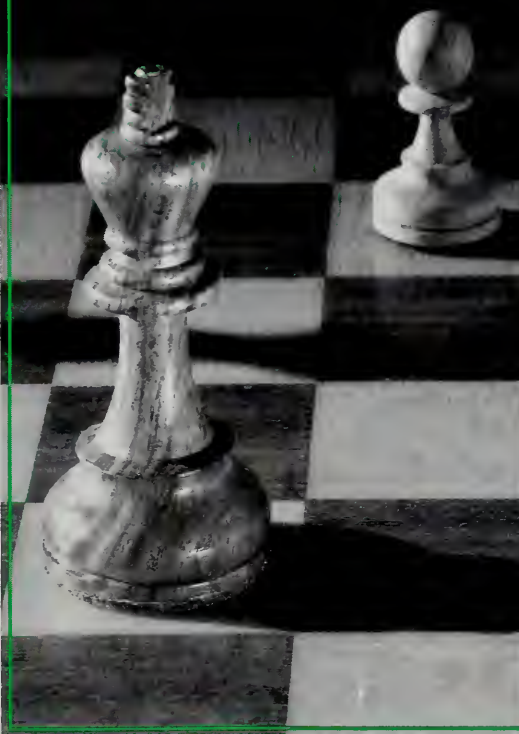
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DISCUSSION

Providers interviewed were painfully aware of the complex cultural interactions that sometimes interfered with their efforts to care for their immi-

grant patients. Their responses indicate a wide range of experience with such barriers, much of it specific to one particular ethnic group. Given the size of the interview group, it is impossible to generalize about immi-

grant behavior, or to make practice recommendations from their comments, but providers' efforts to accommodate diverse patients' health needs, values, beliefs, and practices should be the subject of further study. More research on the effect of cultural assimilation on health care access for immigrants is also needed. **MM**

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Patricia Ohmans is coordinator of the Center for Cross-Cultural Health based in Minneapolis. Craig Garrett is director of the division of General Internal Medicine at Hennepin County Medical Center. Christa Treichel is the president of Cooperative Ventures in St. Paul.

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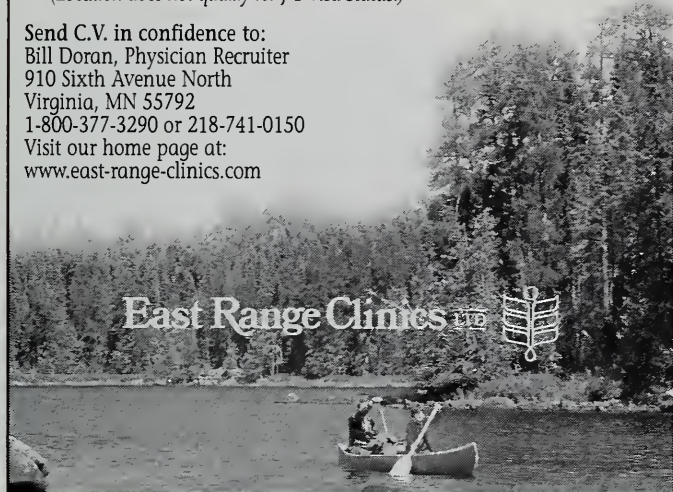
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ANNOUNCEMENTS

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DR. MURRAY IS CALLED TO SERVE

Michael J. Murray, M.D., president of the Minnesota Medical Association, has been called to serve in the U.S. Army Reserves in Germany. In announcing his service orders to the MMA Board of Trustees, Murray quoted former U.S. Surgeon General Antonia Novella who said, "Service is the rent one pays for living," and explained that he considers military duty a way to pay his debt to society. Murray will continue to perform most of his duties as MMA president through E-mail during his four-month absence from Minnesota.

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MMA AND ST. OLAF OFFER ETHICS CONFERENCE

The Minnesota Medical Association and the St. Olaf College Office of Continuing Education and Academic Outreach are jointly sponsoring a day-long conference, "Liberal Arts and the Law—Ethics of Health Care Economics: Access, Availability, and Quality," at St. Olaf College in Northfield on May 31.

The Minnesota Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The MMA designates this continuing medical education activity for 6.5 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

For registration information, call Susan Thurston Hamerski at St. Olaf College, 507/646-3629.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Wins Victories at the Capitol

This was a successful legislative session for the MMA," said David Renner, MMA director of legislation and policy. "We achieved most of our major goals for 1996 and laid the groundwork for next year."

The MMA achieved the following victories:

- defeated the advanced practice nurses' attempt to broaden their scope of practice and prescribing;
- defeated the chiropractors' attempt to win authorization to perform the truck drivers' physical exam;
- defeated the national tobacco lobby's attempt to pass a state law that would preempt stronger local regulations;
- supported funding for the University of Minnesota Academic Health Center.

Responding to resolutions from the MMA House of Delegates, the MMA successfully pushed for passage of bills that will:

- require plans to offer a point-of-service option;
- continue to allow medical records to be used for research;
- require plans to cover a 48-hour postpartum hospital stay; and
- improve laws requiring safe storage of firearms in homes with children by raising the age of a "child" from under 14 to under 18.

The MMA did well despite the fact that the 1996 legislative session, the "short" second half of the 1995-96 biennium, was marked by acrimonious exchanges and political maneuvering that left important health care bills stalled on the House floor.

MMA lobbyist Molly Sigel described this session as "light on policy and heavy on politics." Legislators, up for election in the fall, dragged their feet on enacting proposals that could hurt their chances for reelection.

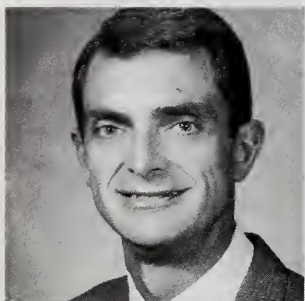
Another factor making it difficult to pass health care bills was the influence of Minnesota Citizens Concerned for Life. For the first time, the MCCL moved beyond opposing abortion and euthanasia and took positions on a wide variety of health care bills, including a strong stand against managed care. The powerful MCCL, in what some critics describe as a "pessimistic and paranoid" view, sees managed care as an excuse to ration care to the disabled and elderly.

House Speaker Irv Anderson, DFL-International Falls, who has strong ties to the MCCL, refused to take up health care bills opposed by the MCCL. As a result, a number of bills stalled, including the point-of-service option, funding for medical education and research, increased eligibility for MinnesotaCare, repeal of the growth limits, and a ban on exclusive contracts. This forced legislators to scramble around during the last few days of session, trying to amend their proposals onto other bills.

Two of the MMA's bills—the repeal of the growth limits and the extension of the ban on exclusive contracts—fell victim to these political maneuvers.

For a more detailed wrap-up of the 1996 legislative session, see pages 35-38.

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Viewpoint

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Michael J. Murray, M.D.
President, Minnesota Medical Association

How Did We Do in '96? How Can We Prepare for '97?

Now that the dust of the 1996 legislative session has settled, we can look back and assess how well the MMA did. Overall, it was a successful session. Usually, the "short" session, the second half of the biennium, is fairly uneventful, but there were a number of significant medical issues, and we won important victories. We improved patient choice with our point-of-service proposal, supported funding for the University of Minnesota Academic Health Center, strengthened the law regarding safe storage of firearms, and fended off the national tobacco lobby's attempt to prevent local communities from enacting their own ordinances to prevent children from buying tobacco. In the toughest battle of the session, we narrowly defeated the chiropractors' persistent efforts to win authority to perform the truck drivers' required physical exam.

Thank you to everyone who testified before a committee, wrote a letter to your local newspaper, contacted your legislator or the governor, or contributed to MEDPAC. We couldn't have succeeded without your help. But the battle is far from over. The chiropractors and others will be back at the Capitol next year. Now is the time to prepare for a successful 1997 session.

As we plan our '97 strategy, it might be useful to look at our great-

est challenge this session—the chiropractors' bill. Although chiropractors are not trained to perform a comprehensive physical examination, they came perilously close to winning the authority to do so. Why?

In a nutshell, once bills move onto the floor of the House and Senate, politics becomes more important than policy. Personal relationships are the driving force. Chiropractors have diligently built good relationships with their legislators and have worked on their campaigns.

Our MMA lobbyists and officers can win on the strength of our arguments in the policy committees, but bills that fail in committee are often resurrected as floor amendments. This happened with the chiropractors' bill.

In the health care committees, lawmakers listened when we said chiropractors are not trained to diagnose serious conditions such as narcolepsy and epilepsy and that truckers who drive huge rigs on the nation's highways should be examined by a physician. The chiropractors' bill failed to meet committee deadlines and was presumed dead, but as MMA lobbyist Molly Sigel said, "It's like the Energizer Bunny. It just keeps coming back."

On the Senate floor, the chiropractors joined forces with the advanced practice nurses and managed to amend their proposal to a transportation funding bill. In the final

hectic days of session when lawmakers were considering a barrage of unfamiliar bills, they paid more attention to phone calls from constituents who contributed money to their campaign, door-knocked for them, or met them in social settings than to the most closely reasoned argument of a lobbyist or a stranger.

This session, the MMA Legislative Network played a decisive role in our success. In the final days, MMA members flooded the governor's office with calls. We narrowly edged out the chiropractors this time, but their calls to legislators outnumbered ours by about 30 to one.

After next fall's election, a new Legislature will be making decisions. All 201 state legislators are up for reelection. Eighteen incumbents have already announced their retirement. It will be a whole new ballgame in 1997. This is a perfect time to help select the players and to build relationships with the incoming team.

How can you prepare for the 1997 session?

- Participate in the 1997 campaign. Legislators appreciate early support. As individuals, we should be out pounding in lawn signs, holding or attending fundraisers, and knocking on doors for the candidates of our choice.

- Remember the state will reimburse you \$50 (\$100 for a couple) for contributions to candidates for state office.

- Contribute to MEDPAC.

- Invite your legislator to spend a day with you, observing your practice. Mini-internships can help legislators understand the problems facing patients and physicians.

- Volunteer to set up a committee to advise your legislator on health care issues. New legislators will especially appreciate having a reliable source of information.

- Invite your legislator to discuss health care issues over coffee.

The MMA's success at the Legislature depends on grassroots support. I urge you to get to know your legislator before the 1997 session convenes.

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LEGISLATIVE SUMMARY

MMA DEFEATS CHIROPRACTIC PROPOSAL

In a series of hard-fought battles, the MMA defeated attempts by the chiropractors to win authorization to perform the physical exams that federal law requires truck drivers to have every two years. The bill was presumed dead after it failed to meet committee deadlines, but when the advanced practice nurses joined the chiropractors, the proposal was resurrected as a Senate floor amendment to a transportation funding bill.

Despite strong MMA opposition, the bill, which would also have raised the gasoline tax and increased the speed limit on some Minnesota highways, passed the Senate and the chiropractors' proposal was included in the conference bill. MMA members flooded the governor's office with calls and letters, urging him to veto the bill. As a result, Gov. Carlson made it clear to legislators that he opposed the chiropractic provision. The House rejected the conference bill 35-96 and sent it back for more work. Conferees were still scrambling to come up with an acceptable bill when they ran out of time.

The MMA Legislative Network played a key role in defeating the proposal this session, but the chiropractors will be back at the Capitol next year, pressing to broaden their scope of practice. See "Viewpoint" for more on this issue.

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MMA DEFEATS INDEPENDENT PRESCRIBING BILL

Thanks to a strong grassroots effort, the MMA blocked a bill that would have given advanced practice nurses unlimited prescribing authority as well as broad powers to practice medicine. The bill failed to receive a hearing in the House or Senate.

After their comprehensive bill died, the nurses sought legislation to clarify that insurance companies

cannot deny claims for orders written by APNs, practicing within their scope of practice under a written protocol with a physician, and to repeal a requirement that the written agreement between the APN and the physician must be filed with the Minnesota Board of Nursing. As a result of this legislation, the agreement must be kept on file at the practice site.

The MMA supported the nurses' limited proposal, which was signed into law as part of the Omnibus Insurance Bill, Chapter 446. The MMA will continue working with the nurses to resolve problems. Meanwhile, the Minnesota Board of Nursing is developing its own recommendations.

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POINT-OF-SERVICE OPTION IS SIGNED

Responding to a 1995 resolution, the MMA initiated a bill to require every health plan in Minnesota to offer at least one point-of-service option at a cost that must be "actuarially justified." In a victory for patient choice, a modified bill requiring every plan in the small- and large-group market to offer a point-of-service option passed and was signed into law as part of Chapter 446, the Omnibus Insurance Bill. Existing law requires plans to seek approval of the premium rates for the small-group market and to file rates for the large-group market.

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MMA HELPS WIN U OF M FUNDING

The MMA supported increased funding for the University of Minnesota's Academic Health Center. Money for medical education and research was a top priority for Gov. Carlson, who requested more than \$14 million in his 1996 budget. As the session proceeded, however, it seemed unlikely the

center would get more than \$4.5 million. The adverse publicity generated by the Najarian case and controversy surrounding the University of Minnesota/Fairview merger made legislators unwilling to loosen the purse strings.

At the governor's request, the MMA, along with other health care organizations, joined a vigorous grassroots lobbying effort to increase the university's funding. As a result, the Academic Health Center will receive \$8.6 million in new money. The bulk of the money will be used for restructuring the center to improve education for health care providers.

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MEDICAL RECORDS RESEARCH BILL IS SIGNED

The MMA initiated a bill to repeal the 1997 sunset of a provision allowing medical records to be released and used for medical research without the patient's authorization. Repeal of the sunset, which passed as part of the Omnibus Data Privacy Bill, proved to be one of the most controversial issues facing the conference committee.

In a compromise reached after much debate, the final provision requires that after January 1, 1997, all patients must be given written notice that their medical records may be used for research purposes and that they have the right to object to the release at any time.

The new law also requires providers to note in the medical record when information in the medical record is released without the patient's authorization. This applies not only to release for research purposes, but to any release permitted by law. The MMA is analyzing the impact of this provision on physician's practices. The medical records provision, which responds to a 1995 MMA resolution, has been signed into law as part of Chapter 440, the Data Privacy Bill.

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LEGISLATIVE SUMMARY

FIREARM SAFETY LAW IMPROVED

Responding to a 1995 MMA resolution, the MMA initiated a bill to require stored firearms to be locked in homes where children under age 18 are present. The National Rifle Association bitterly opposed this bill. Despite moving testimony in favor of the bill by the mother of a young gunshot victim and by teenagers who face the dangers of readily accessible guns, lawmakers deleted a provision defining what is meant by safe storage of a firearm.

The MMA did succeed in raising the age when "reasonable action" must be taken to prevent a child from gaining access to a firearm from under 14 to under 18. This is a major accomplishment. Three-fourths of the gun deaths among Minnesota children occur in the 15 to 18 age range. The age increase passed and was signed into law as part of Chapter 408, the Omnibus Crime Bill.

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MMA DEFEATS TOBACCO LOBBY

The MMA and other members of the Smoke-Free Coalition successfully fought off attempts by the national tobacco industry to pass a law that would have prevented local municipalities from passing more restrictive tobacco sales laws than the state. The tobacco lobby's preemption provision, which was amended to an MMA-supported bill to toughen the law governing the sale of tobacco to minors, was deleted on the House floor, and the bill was pulled by the author.

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BMP BILL SETS STATUTE OF LIMITATIONS

The MMA reached agreement with the Board of Medical Practice before the 1996 legislative session began, so the BMP bill that moved through the

Legislature was not controversial. In a negotiated victory for the MMA, the BMP bill adds a seven-year statute of limitations to the Medical Practices Act for all complaints except those alleging sexual misconduct. The MMA has long sought a statute of limitations.

The BMP bill also adds a step to the disciplinary process dealing with contested cases alleging physician sexual misconduct. If a sexual misconduct case is not resolved by the complaint review committee conference and is about to proceed to a contested case hearing, either the BMP or the physician may request a probable cause hearing before an administrative law judge. If the ALJ finds there is probable cause to believe there has been sexual misconduct, the matter proceeds to a contested case hearing. At this point, the notice of the hearing alleging sexual misconduct becomes public data.

If the BMP ultimately finds there has been sexual misconduct and imposes disciplinary sanctions, the ALJ's findings of fact, conclusions, and recommendations to the BMP and the transcripts of any oral arguments before the BMP become public data. The MMA succeeded in limiting the change in the disciplinary process to sexual misconduct cases and in inserting the extra step of the probable cause hearing before the notice of the contested case hearing becomes public information.

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CRIMINAL BACKGROUND CHECKS SIMPLIFIED

The process for criminal background studies, required by the 1995 Vulnerable Adults Act, has been streamlined for providers who have direct contact with vulnerable adults at many different sites. The MMA was instrumental in reaching an agreement that allows physicians to

complete one data release form, listing each facility where they have contact with vulnerable adults. Under the new process, the Department of Human Services will serve as a central clearinghouse for information on criminal background studies and will, upon request, notify the various sites about the outcome of the studies. This change was signed into law in the Omnibus Crime Bill, Chapter 408. The MMA will continue to be involved in fine-tuning the process and will participate in a study group looking at the impact and feasibility of the background study requirement.

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POSTPARTUM COVERAGE LAW TAKES EFFECT

Responding to a 1995 resolution, the MMA supported legislation to require all Minnesota insurers that cover maternity benefits to cover a minimum 48-hour hospital stay following a normal vaginal delivery and a 96-hour stay following a cesarean section. The bill passed the House and Senate by overwhelming margins and took effect March 19, 1996. The new law prohibits health plans from offering the mother compensation to encourage her to go home earlier and requires health plans to cover a follow-up home visit by a registered nurse if the mother chooses to go home sooner than the minimum covered stay.

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PROSTATE CANCER SCREENING BILL IS SIGNED

A bill requiring health plans to cover prostate cancer screening passed and was signed into law as part of the Omnibus Insurance Bill, Chapter 446. This law requires all health plans to cover prostate screening for men age 40 and older who are symptomatic or at high risk, and for all men age 50 and older. The

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LEGISLATIVE SUMMARY

screening must consist, at a minimum, of a prostate-specific antigen blood test and a digital rectal examination. The MMA took no position on this bill.

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INSURANCE FOR ABUSE VICTIMS BILL IS SIGNED

Responding to a 1994 MMA resolution, the MMA supported a bill prohibiting insurance discrimination to victims of domestic violence. A bill passed and was signed into law as Chapter 278, which prohibits insurance companies that sell life and health insurance from underwriting based on the incidence of domestic violence. The insurance industry and the MMA supported this bill.

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LYME DISEASE AND IMMUNIZATIONS MUST BE COVERED

Health plans must cover treatment for diagnosed Lyme disease, under a provision signed into law in Chapter 465. No health plan may impose a special deductible, copayment, waiting period, or other special restriction on Lyme disease treatment that the health plan does not apply to non-preventive care in general. This provision takes effect August 1, 1996.

Also included in Chapter 465 is an amendment raising the age when state law requires health plans to cover childhood immunizations. The requirement is changed from "birth to age 6" to "birth to age 18."

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BENEFITS REVIEW PROPOSAL FAILS

A bill to require the commissioner of health to assess any proposed addition to the state's mandated benefits set was included in the Senate version of the Omnibus Insurance Bill but was deleted in

conference committee. The proposal came in response to an increasing number of requests that the Legislature require insurers to cover certain health care benefits. The MMA supports the concept of a review process.

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MINNESOTACARE ELIGIBILITY EXPANSION VETOED

The MMA supported a bill that would have expanded MinnesotaCare eligibility from the current level of 125 percent of the federal poverty level to 150 percent. Despite the large surplus in the health care access fund and the bill's broad support from health care and business groups, Gov. Carlson vetoed it, saying that expansion of the MinnesotaCare program for adults should be approached "incrementally." In his veto message, the governor did, however, authorize the commissioner of human services to expand MinnesotaCare eligibility to 135 percent of the poverty level beginning July 1, 1996.

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EXTENSION OF EXCLUSIVE CONTRACT BAN FAILS

The MMA pushed for a bill that would have extended the ban on exclusive provider contracts until the year 2000. The ban was enacted in 1994, at the urging of the MMA, so that health care providers could negotiate contracts with many different health plans without being pressured to sign exclusive contracts. The ban is due to sunset January 1, 1997. The MMA will seek an extension again next session.

The bill passed out of policy committees in the House and Senate and passed off the Senate floor. Its progress came to an abrupt halt on the House floor, however, when Speaker Rep. Irv Anderson, DFL-

International Falls, refused to call the bill up for consideration. MMA lobbyists believe the bill stalled because Anderson feared Health and Human Services or abortion-related amendments would be added to the bill. Another factor was the strained relationship between the Speaker and the bill's author, Rep. Roger Cooper, DFL-Bird Island.

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GROWTH LIMITS BILLS FAIL

A proposal to repeal the state growth limits was amended onto the bill to extend the exclusive contract ban, which stalled on the House floor. Another growth-limit proposal was vetoed as part of the recodification bill. This provision would have repealed a 1995 law requiring providers who comply with state growth limits by limiting their fees to base growth limits solely on the regional consumer price index for urban consumers. Despite these setbacks, there is a good chance the growth limits may be repealed next year. The Minnesota Department of Health and the governor support repeal of the growth limit enforcement provision.

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PMAP WON'T BE DELAYED

The governor vetoed the first Health and Human Services Omnibus Bill that landed on his desk because it would have delayed implementation of the state's Prepaid Medical Assistance Program (PMAP). The final Health and Human Services bill, which was signed into law as Chapter 451, allows PMAP to expand into all Minnesota counties by July 1997, as originally scheduled, but it also requires the Department of Human Services to work more closely with the counties on the implementation of PMAP.

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LEGISLATIVE SUMMARY

FEE-FOR-SERVICE REQUIREMENT

The commissioner of human services must develop a fee-for-service option for MinnesotaCare enrollees, according to a provision added to Chapter 451, the final Health and Human Services Bill. The fee schedule for the fee-for-service option may not exceed 20 percent of the premium fees.

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REPORT ON DIRECT CONTRACTING

The commissioners of health and commerce will jointly study the feasibility of allowing direct contracting by providers. Their report must include recommendations on consumer protections and solvency requirements. The commissioners must report their findings to the Legislative Oversight Commission on Health Care Access by December 15, 1996.

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COOPERATIVE DEMONSTRATION PROJECT EXPANDED

Two additional Southwest Minnesota provider cooperatives will be able to participate in a demonstration project allowing them to contract directly with self-insured plans. The provider cooperative demonstration project was established by the 1995 Legislature and will sunset December 31, 1999.

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RESIDENCY REQUIRED FOR MEDICAL ASSISTANCE

At the urging of House Republicans, a provision was included in the Health and Human Services Bill that establishes a 30-day residency requirement for Medical Assistance eligibility. The residency requirement can be waived in cases of medical emergency or when unusual hardship would result from denial of

assistance. Current law only requires that a person "reside" in the state.

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DISCOUNTED DRUGS FOR SENIORS

After the failure of a comprehensive bill to create a state drug purchasing pool, a provision was included in Chapter 451 that requires the commissioners of health, human services, and administration to develop a plan to provide prescription drugs at significantly discounted prices to seniors 65 years of age or older whose incomes are below 200 percent of the federal poverty level, \$15,480 for an individual and \$20,720 for a couple. The report must be submitted to the Legislature by October 1, 1996.

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MINNESOTA NEWS

MINNESOTACARE Will Soon Move to Managed Care

All 90,000 MinnesotaCare enrollees are scheduled to be converted to managed care by October 1996. The 20,000 MinnesotaCare enrollees in Hennepin and Ramsey counties will be moved into managed care plans by July 1996. The state has signed contracts with Blue Plus, HealthPartners, Central Minnesota Group Health Plan, Itasca Medical Care, Ucare, and Medica to provide managed care. In 28 of Minnesota's 87 counties, Blue Plus will be the only choice for MinnesotaCare enrollees.

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DHS ADOPTS FINAL RULES ON SECOND OPINIONS FOR SURGERY

The Minnesota Department of Human Services has adopted final rules governing second surgical opinions for Medical Assistance, General Assistance Medical Care, and MinnesotaCare patients. The former rules required physicians to obtain a second opinion prior to surgery in order to be reimbursed by DHS for a tonsillectomy, adenoidectomy, cholecystectomy, or hysterectomy. The newly adopted rules allow physicians to obtain the approval either before or after the surgery. Approval is still required to obtain reimbursement.

The MMA Committee on Medical

Practice and Planning, which reviewed the rules, expressed frustration with Minnesota law requiring a prior authorization process, but found the new rules to be an improvement. Patients who need surgery may no longer face delays while their physicians try to obtain a second opinion.

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NEW MEMBER APPOINTED TO BMP

Gov. Arne Carlson has appointed MMA member James B. Gavisser, M.D., a plastic surgeon in Minneapolis, to the Minnesota Board of Medical Practice.

Zero Tolerance Toward Racial or Cultural Disparities in Health Care

To prevent what an AMA Board of Trustees report described as a "nightmare within the U.S. health care system," the AMA House of Delegates at its December 1995 Interim Meeting adopted a position of "zero tolerance" toward racially or culturally based disparities in health care. The call to zero tolerance was one of 11 recommendations adopted by the AMA to address the persistent barriers encountered by minority groups in obtaining access to health care.

The AMA adopted a BOT report calling on the AMA to take the following action:

- Maintain a position of zero tolerance toward racially or culturally based disparities in care.

- Consolidate AMA policy on meeting the health care needs of minority patients and communities and present this policy consolidation at the 1996 AMA Interim Meeting.

- Continue to support physician cultural awareness initiatives and consumer education activities, such as the publication *Culturally Competent Health Care for Adolescents*, and develop a series of publications on culturally competent health care.

- When it is relevant, consider and comment on the impact on minority populations when testifying before Congress or commenting on regulatory proposals.

- Develop assessment tools to enable individual physicians and groups of physicians to identify and act on care disparities.

- Encourage individuals to report physicians to local medical societies when racial or ethnic discrimination is suspected and develop a process to be used by local medical societies in instances when they are told about a physician's alleged violation of the AMA's ethical stand against racial or cultural discrimination.

- Continue to strengthen relationships with organizations representing minority physicians, including the National Medical Association.

- Communicate AMA policies related to meeting the health care needs of minority populations with the Office of Minority Health, Department of Health and Human Services, and initiate and maintain a two-way line of communication with this office.

- Develop, possibly with data pooled from hospitals and other sources, and regularly use a survey instrument to identify the degree of racial and ethnic disparities in health care.

- Regularly monitor and report on progress being made to address racial and ethnic disparities in care.

- Disseminate this report throughout the Federation with a request that it be distributed to local physicians and serve as the basis for organized discussions.

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MMA Targets Racial or Cultural Disparities in Health Care

• • • • • STEPS ARE ALREADY UNDERWAY in Minnesota to reduce racial and cultural barriers to health care. In 1991, the MMA developed the MMA Committee on Minority Affairs, currently chaired by Dennis Hines, M.D. The committee focuses on how various cultural practices and beliefs affect health care and helps physicians understand patients' cultural differences. This is an important issue for Minnesota health care providers. Minnesota's population includes about 49,400 Native Americans,

75,000 Hispanic people including 20,000 migrant workers, and a 10 percent African-American population in the Twin Cities. In addition, Minnesota is home to the country's second largest population of Hmong refugees from Laos. More than 70 languages are spoken in Minneapolis schools. One of the projects of the MMA Committee on Minority Affairs is to select a nominee for the Minority Service Award, which is presented at the MMA Annual Meeting to recognize extraordinary service to minority patients.

Later this year, Minnesota physicians will have another resource to help them become more sensitive to cultural differences that affect health care. The 1995 MMA House of Delegates voted to support and help fund the development of a Center for Cross Cultural Health, which is scheduled to begin operation in late 1996. Currently, the center is updating a cultural resource directory to include information and articles on various cultures, bibliographies, speakers, etc. See related article on page 12 of *Minnesota Medicine* for more information about the Center for Cross Cultural Health.

MINNESOTA NEWS

NATIONAL RURAL HEALTH CONFERENCE IS SCHEDULED

The National Rural Health Association will hold its annual national conference May 15 to 18 at the Hyatt Regency in Minneapolis. The conference will include practical clinical sessions, discussion of policy issues affecting rural health services, personal and professional skills development, and presentations of recent rural health research results. In addition, the program will feature exhibits of the latest products and services, social functions, and the NRHA awards luncheon honoring excellence in the rural health field. For registration information, call the NRHA at 816/756-3140.

FINAL MERC REPORT SENT TO LEGISLATURE

The Minnesota Department of Health has issued a final report to the Legislature on Medical Education and Research Costs (MERC). The report is the result of three years of study and debate by the MERC Advisory Task Force. Copies of the report can be obtained from the Health Information Clearinghouse, 121 East Seventh Place, PO Box 64975, St. Paul, MN 55164-09765.

HTAC UPDATE

Susan Esernhagen of Duluth, an employer representative on the Health Care Technology Commission, will replace Del Ohrt, M.D., as chair of HTAC.

Members of HTAC were disappointed that the Legislature ignored their draft "Evaluation Report on Post-delivery Care of Mothers and Newborns" and their testimony before the Senate Health Care Committee regarding the post-partum-stay bill, which requires insurance companies to cover a 48-

hour hospital stay following delivery. HTAC opposes a legislative mandate of any minimum requirement of length of stay as "inappropriate and unnecessary." The commission's draft report states that the needs of the mother and baby should be assessed on an individual basis.

DO YOU HAVE CONCERNS ABOUT TIMELY TREATMENT DECISIONS FOR STATE WARDS?

The 1995 MMA House of Delegates adopted a resolution directing the MMA to study Minnesota law regarding the establishment of advance directives for patients who are state wards and to make recommendations to promote timely treatment decisions. MMA legal staff, who are currently studying this issue, would find it helpful to know about any specific instances when there have been difficulties in making timely treatment decisions when dealing with the state of Minnesota acting as guardian for state wards. Please direct specific concerns and responses to Patricia Franklin, director of legal affairs, at 612/378-1875 or 800/999-1875.

DHS WILL SUBMIT PHASE 2 WAIVER REQUEST

The Minnesota Department of Human Services is submitting Phase 2 of its request for a federal waiver. The waiver would allow Minnesota to set up a pilot project to provide Medical Assistance for the disabled. DHS will also include in its waiver a 30-day residency requirement for MA eligibility and a change in the look-back requirement for asset transfer.

MMA CAMPAIGN AGAINST VIOLENCE IN THE MEDIA IS TOPIC AT AMA LEADERSHIP CONFERENCE

Mark Vukelich, MMA director of communications, addressed the AMA Leadership Conference in Washington, D.C., on March 10 on the importance of public health issues in physician communications efforts. Vukelich gave an overview of the MMA's public health initiatives, including the campaign against tobacco, youth access to guns, and domestic violence, with special emphasis on the MMA campaign against violence in the media. He explained that these public health campaigns give the MMA an opportunity to network with the governor's office, the attorney general's office, and with other groups interested in health and safety issues. "Public health issues are good for the community and good for the physician's image," Vukelich said. This fall, the MMA and the AMA will work together to promote the MMA campaign against media violence throughout the nation.

The Monitor

MAY 1996

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Integrating Culture and Healing

Meeting the Health Care Needs of a Multicultural Community

Amy E. Johnson, B.A., and George V. Baboila, M.S.W., L.I.C.S.W.

ABSTRACT

Delivering health care to culturally diverse patients is fast becoming an integral part of patient care—a change driven by shifting demographics in Minnesota and especially in the Twin Cities metro area. At United Hospital and Children's Health Care—St. Paul, ethnographic research is being used to create cross-cultural health care information systems that address the needs of providers and patients. These include an easy-to-use computer-based information system, brown bag seminars, and cross-cultural skills training. This article discusses the hospitals' efforts to identify provider needs, collect cultural information, and disseminate that information in a manner that supports quality and cost-effective health care delivery.

Have your patients presented with symptoms like the following?

Estoy empachado. Estoy inflada. Creo que comi mucho. Me duele el estómago. Necesito medicina; or

Kuv tus menyuum muaj ntsis kub tob hau, kuv ntshai tsam nws ua qoob thiab qoob zwm hauv nws lub cev lawm. Koj puas muaj tshuaj ab tsi yuav ua kom cov qoob ntawd tawm nto.

Chances are they will. Minnesota's population is fast becoming more diverse—a change that means physicians will increasingly be seeing patients from cultures different from their own. Thus, it is critical that health care providers gain cross-cultural skills and knowledge to serve our changing communities.

To understand and meet the needs of employees and patients from the diverse cultural communities of St. Paul, Minnesota, United Hospital and Children's Health Care—St. Paul have created the Diversity Action Council, a shared initiative between the two hospitals. One goal of the initiative is to help health care providers deliver competent cross-cultural health care by creating a computer-based Cross-Cultural Health Care Information System based on ethnographic research by a medical anthropologist (author AEJ).

The research goal is to address the specific concerns and experiences of patients and providers at the two hospitals. This will be accomplished by including the voices of both patients and providers through a research process that includes asking patients, communities, and providers to share their concerns and suggestions for culturally competent health care.

This paper discusses the results of our research into provider concerns

and information needs and includes a Cultural Assessment Guide that other health care organizations can use when serving culturally diverse communities.

METHODS

We began by formulating a research plan, adapted from "Ethnographic Research Methods For Applied Medical Anthropology,"¹ to create a computer-based Cross-Cultural Health Care Information System—a readily available resource for providers who treat patients from various cultures. First in this research plan, we identified the needs of health care providers at Children's Health Care—St. Paul and United Hospital in delivering care to patients of diverse cultural backgrounds. We used the collected information to create a Cultural Assessment Guide that can be used in conjunction with ethnographic methods to study the health values, beliefs, and behaviors of different cultural communities (see page 42).

The needs assessment entailed asking providers to share their concerns and experiences in delivering care across cultures and asking former patients from various cultural communities to share their insights, concerns, and suggestions. We used observation of staff in their roles, informal interviews, and many focus group discussions to identify the needs of health care providers.

RESULTS

The focus groups pinpointed topics of interest and concern to health care providers, revealed how providers anticipate using cultural information on a computer-based system, and identified potential barriers and aids to success. We used this information to create a format for the computer

system and to recommend other resources and projects to supplement the computer resource.

CULTURAL ASSESSMENT GUIDE

Topics of interest are listed in the Cultural Assessment Guide (below), a framework of subjects and questions regarding cross-cultural health care. It is presented here as a guide-

line for other researchers and interested health care professionals to research the cultural communities they serve. Health care providers may also use it to assess the cultural beliefs and backgrounds of their patients in the clinic or hospital setting. Our computer-based system will address each of the categories in the Cultural Assessment Guide.

THE USE OF CULTURAL INFORMATION IN MEDICAL PRACTICE

The Cross-Cultural Health Care Information System should alert providers about diagnoses, treatments, and medications that will require more explanation than is typical. The program also will provide references and a bibliography of pertinent reading material. It will list community

Cultural Assessment Guide for Investigating Health in the Context of Culture

Basic Cultural Background

History: Where does this community come from? What was life like in their home country? What are the issues surrounding their immigration (if new immigrants or refugees)? What diseases are endemic where they are from (for recent immigrants especially)?

Language: What language(s) are spoken in this community?

Religion: What are the spiritual beliefs and religions in this community? How might this affect daily routine?

Food: What foods are common? Are certain foods not eaten? What are the social rules surrounding food? Can food cure certain illnesses?

Names: How are people named? Do given names or family names come first? Do people change their names at major life events, such as marriage?

Local Community: What social services are offered within this community? How does this community identify itself? Is it a cohesive or divided community?

Acculturation: How long has this community been in St. Paul and Minneapolis? Are there differences in stages of acculturation throughout the community? How might this affect the use of, understanding of, and experience of the health care system in St. Paul and Minneapolis?

Issues of Concern to the Community: What are the major issues of concern to the community? What does the hospital experience mean to the community? Have members of the community had negative experiences that we might be unaware of? What are common fears in seeking health care? What are common expectations for care? What are potential barriers to care for this community? What are potential problems and/or misunderstandings with the biomedical community?

Culture Indirectly Affects Health and Illness

Role of Family: What is the structure of the family? Who does "family" consist of? Is there a gender and/or age hierarchy? How and for what reasons are children valued in this culture? What role does the family play in the individual's life? What is the division of labor in the family? How are decisions made in the family? Who makes decisions in the family? Who speaks for the individual? Who speaks for the family?

Role of Community: Who makes decisions in the community? How are community decisions made? What are the family's expectations of the community and the community's expectations of the family? What are the individual's expectations of the community and vice versa?

Communication:

- **Verbal Communication:** What are the forms of courtesy in speech? What is the formality of greeting? What are polite/impolite subjects of conversation? What is sensitive information, and what are some culturally correct ways of talking about it? Are questions asked directly or indirectly? What actions or words are considered insulting or threatening?

- **Nonverbal Communication:** Do members of this community shake hands or not? Do they make eye contact or not? How do members of the opposite sex interact? What is appropriate touch?

Social Relationships:

- **Social Status:** Are there age, economic, or gender distinctions in social status? What measures success, status, and esteem?

- **Gender:** What are the roles of men and women in this culture? How do men and women relate to each

resources and contact people for culturally specific programs and projects and provide information about interpreters. Most important, the program will include tips on building provider skills in crossing cultural barriers.

We asked providers to consider how they might integrate cultural information into their daily practices.

Providers suggested using the computer-based Cross-Cultural Health Care Information System prior to an encounter to get an idea of differences in health care approaches, food preferences, religion, family systems, social structures, and appropriate communication skills when caring for a patient who comes from a cultural background different from the

provider's. Providers also anticipated using the Cross-Cultural Health Care Information System to identify possible misunderstandings in their patient encounters.

Providers can use the cultural information to generate pertinent questions about an individual's belief system—a skill necessary for providing competent cross-cultural

other? How are members of the opposite sex addressed?

- Respect: How does one gain respect in this community? How is respect shown in this culture? Who is respected in this culture?

- Trust: What interactions require permission, or a certain level of trust? How is trust gained? Who do people look to for help? When is something a "private" or "family" issue? What defines a "private" issue? What defines a "family" issue?

Culture Directly Affects Health and Illness

Health and Illness Beliefs: What is the definition of "health"? What is the definition of "illness"? What are the possible causes of illness? How are sickness and health talked about? How are anatomy and bodily functions understood? What does it mean to be sick in this culture? How do people present themselves as patients? What are common expectations of care and of recovery? How are attempts at changing the course of an illness viewed? How is pain perceived and experienced? How do religious beliefs affect the understanding and experience of health and illness and the treatment of illness?

Grief and Dying: How is death viewed in this culture? Is it feared or embraced? How is suicide viewed? Is end-of-life decision-making the right and responsibility of the individual or the family? What are common attitudes toward advance directives? What are common expectations concerning medical care for the dying—palliative or aggressive treatment? Are there ritual and religious aspects of death? Do religious leaders stay with a dying patient, and are there others who may be called for this reason? What kind of comfort is welcomed or expected for the dying patient? For the family? Is touch appropriate? Are there

words of comfort to say to the family at this time? What issues face a family that just lost a loved one?

Seeking Health Care in the United States:

- Choosing a Health Care Provider: How do people decide which healer or healing method to seek? Who makes this decision for the sick person? Do people consult several healers and methods at the same time? Is there a common order of resort to different healers and methods? How do patients approach treatment plans?

- Attitudes Toward Healers: What do people look for in a health care provider? Are relationships between healers and patients authoritative, cooperative, or threatening and fearful? How does this affect communication and provider-patient interaction? Is it acceptable for a patient to have a health care provider of the opposite sex?

- Community Health Care: Who are the healers and what distinguishes them? What are traditional healing modalities, and how are they performed or administered? What are the traditional medications? Who gives them out? How are they taken?

- Institutionalized Health Care: What are some common cultural expectations of a health care provider? Are there mannerisms or ways of communicating that are conducive to building trust? Are there barriers to a working relationship based on differences in expectations and communication modes? What kinds of procedures or exams are unacceptable or threatening? How are they understood and experienced, even when agreed to? How are prescriptions received, used, and understood? Why might a family refuse care? Is there a decision-making process that health care providers should be aware of? Are there ways a provider should work with this process?

Methods for Creating and Enhancing a Health Care Setting that Serves a Culturally Diverse Community

Information Resources for Staff

Classes and Workshops on Cross-Cultural Health Care

- Diversity training;
- Diversity seminars on culture, health, and healing (videotaped and made available to all shifts);
- Basic language classes on name pronunciation, basic words and phrases;
- Grand rounds on cross-cultural issues;
- Advertising of transcultural nursing and cross-cultural medicine workshops.

Written Materials on Cross-Cultural Health Care

- Center for cultural information: books, manuals, videos, brochures, language resources;
- Distribution of articles on cross-cultural health care to physicians, nursing units;
- Newsletters (physician, employee) on cross-cultural issues;
- Computer-based information resource, like the Cross-Cultural Health Care Information System;
- Computer-based bibliography of cross-cultural health articles, books.

Interpreters and Translators

- Rapid access to interpreter services;
- AT&T language line when necessary;
- Training of physicians and staff on the most effective and appropriate use of an interpreter;
- In-house trained interpreters who can also act as cultural brokers;
- Bilingual cards showing pictures paired with simple words and phrases for patients and providers to communicate basic needs and requests.

Community Outreach

A Welcoming Atmosphere in the Hospital

- Provide and advertise transportation availability for patients and family;
- Increase the cultural diversity of the patient care staff (see Community Education, below);
- Offer a videotape on the hospital for families waiting in the emergency department that explains

basic registration and admitting procedures, that tells them an interpreter will come to help them and that assures them they will not be harmed;

- Have a bilingual, bicultural person accompany patients and families through the admissions process for basic, nonmedical interpretation, comfort, and support;
- Provide hospital directions printed on disposable card-sized maps or overhead signs in multiple languages;
- Make culturally and linguistically diverse reading material available in family waiting areas;
- Allow families to bring food in for patients whenever possible;
- Accommodate large families and overnight visitors when possible;
- Make culturally and linguistically diverse TV stations or programs available for patients and families.

Community Education

- Provide bilingual patient education materials (written, video);
- Use bilingual consent forms, clarifying that a patient may consent to all or just parts of the procedure. Incorporate diagrams and simple language to help explain;
- Offer community education about biomedical culture and healing beliefs, insurance, what to expect from the health care system, and how to access the system;
- Offer classes in community settings in languages other than English, by community members, and addressing issues of concern to that community (e.g., Hmong-language childbirth classes taught outside the hospital by a Hmong nurse and addressing unique concerns of childbearing in Hmong and Hmong-American cultures);
- Set up a mentor program at the hospitals for employees and people in the community to promote advancement in the health care professions;
- Offer ESL and vocational training to recent immigrant communities, preparing them for employment in health care.

health care. Providers may ask questions from the Cultural Assessment Guide; however, open-ended questions tend to elicit more information. For example, the question, "Have you seen an herbalist?" only asks about one healer, while the question, "What people have you seen to help you with this problem?" may prompt a patient to talk about family members, herbalists, shamans, masseuses, acupuncturists, and others.

In order to ask appropriate questions and to understand answers, providers must have basic knowledge about a culture. The Cross-Cultural Health Care Information System will enable providers to formulate culturally specific questions from basic information about cultural beliefs. For example, a 22-year-old Hmong woman is delivering her first child, and her mother-in-law is present. The computer-based program may prompt a provider to ask the woman whether she would like ice chips or hot water. She may request the ice chips if she does not subscribe to traditional Hmong health beliefs. Or she may request hot water because she believes her body becomes cold and weak with delivery of the child, or because she wants to respect her mother-in-law's beliefs. Understanding a cultural belief system helps providers ask appropriate questions, resulting in more effective care.

BARRIERS AND AIDS TO SUCCESS

Providers emphasized that the information should be easily accessible. We determined that the computer system should contain basic cultural information in an indexed form so that certain components can be accessed separately; basic information should be linked to in-depth explanations and references for further inquiry. Both basic and in-depth information should have print capability so the resource is available to providers without computer access or computer skills. Providers also requested lists of community resources and services, as well as interpreter³ and translator information. Both cultural and reference information will be updated as changes in the community and the literature occur.

In addition, providers may lack background knowledge about what culture is and how it affects experiences. Several providers requested training on the appropriate use of cultural information, cross-cultural communication skills, and inquiry into cultural values and beliefs.

Because cultures and communities change, cross-cultural health care initiatives must also be changeable. Several physicians noted dangers associated with providing simplified information on culture, such as creating and perpetuating stereotypes of cultural groups and representing culture as static.

The Cross-Cultural Health Care Information System will include a disclaimer conveying the message, "*Cultures are always changing, and no culture represents the whole of an individual. The following is generalized cultural information which may be used only to guide your questions and assessment of an individual from that culture.*" It will include guidelines on the appropriate use of interpreters, self-cultural assessment questions, and examples of open-ended questions about patients' beliefs and experiences. Together, these resources will help providers recognize their own culturally based beliefs and experiences and begin to understand the concept of culture.

DISSEMINATING CULTURAL INFORMATION

A variety of resources and approaches to skills training is necessary for teaching the competent delivery of care across cultures. Learning to be culturally competent is an ongoing process. In addition, some providers are not computer proficient and require information in other accessible formats.

United Hospital and Children's Health Care-St. Paul are using a number of approaches, including classes and cross-cultural skills training, as outlined on page 44. As part of the hospitals' Diversity Action Council's brown bag sessions, for example, in March 1996 a noted Hmong scholar presented a program on health and healing within the Hmong culture. Having knowledgeable community members present lectures brings the

voice of patient populations to health care providers. Other suggestions include holding grand rounds on cross-cultural issues and adding cultural information and insights to the hospitals' physician newsletters.

Participants in our research noted that community outreach would ensure that the hospitals hear and meet the needs of their patient populations. One suggestion is to increase the cultural diversity of the patient care staff, creating a welcoming atmosphere within the hospital and providing educational opportunities to the community. Sponsoring or providing English as a Second Language classes and vocational training in the community would increase the availability of culturally diverse health care providers to care for patients from various cultural communities. When culturally diverse communities and health care systems are integrated through employment, providers can look to one another for information on culture and healing.

SUMMARY

As health care changes, the challenge for providers is determining how best to meet patient needs. Knowing and understanding our changing patient populations will enhance the quality of care and minimize the cost of service. The Cross-Cultural Health Care Information System and the other initiatives resulting from the ethnographic research underway at Children's Health Care-St. Paul and United Hospital aim to do just that.

MM

Amy Johnson is a medical anthropologist employed at United Hospital to coordinate and conduct this research. She is a member of the Information, Resource and Referral Committee for the Center for Cross-Cultural Health in Minneapolis. She will enter medical school this fall. George Baboila is the director of Social Services at United Hospital and a trainer for the Diversity Action Council.

REFERENCE

1. Trotter RT II. Ethnographic research methods for applied medical anthropology. In: Hill CE, ed. Training manual in applied medical anthropology. Washington, D.C.: American Anthropological Association, 1991:180-211.

Developing Preventive Health Programs for Recent Immigrants

A Case Study of Cancer Screening for Vietnamese Women in Olmsted County, Minnesota

Ann H. Tosomeen B.A., Miriam A. Marquez, Ph.D.,
Laurel A. Panser, M.A., M.S., and Thomas E. Kottke, M.D.

Editor's Note: Providing health care to all Minnesotans will require greater attention to individuals of diverse cultural and ethnic backgrounds. Many of these individuals do not understand our medical systems, our diagnoses, or our treatments. Nor do they understand the language we use to explain them. Public health departments or special clinic facilities are not available to care for recent immigrants in many of our communities. If we do not devise ways to provide ambulatory and preventive care for these individuals, we will need to provide more intensive and complex care later.

In this public health report, the authors describe their experience in providing preventive care for Vietnamese women. Not every physician can provide similar services, but every community can learn from the barriers discussed in this article and develop their own strategies for bringing recent immigrants into our health care system.

—Barbara P. Yawn, M.D., M.Sc.
Series Editor

The face of Minnesota is changing with the arrival of new populations—many in need of disease prevention services. We describe a project designed to identify and eliminate barriers to health education and cancer screening services for adult Vietnamese women in Olmsted County, Minnesota.

Studies indicate that Asian-American women tend to underutilize preventive services, particularly breast and cervical cancer screening. Studies of Chinese¹ and Vietnamese² women residing in the United States identify modesty and fear of losing one's virginity during a Pap smear as cultural barriers to attaining services, particularly for unmarried women. Lack of knowledge about cancer risk factors and the benefits of screening are cited as barriers for Cambodian³ and Vietnamese⁴ women. Also restricting access to preventive services are institutional barriers, such as the unavailability of information in native languages, the absence of educational campaigns, the cost of services, and the limited number of female physicians.¹

Our project includes three components: identification and contact of the adult Vietnamese women residing in Olmsted County, 12 community educational meetings held at a public school, and eight clinical screening sessions providing clinical breast examinations, mammograms, and Pap smears. Figure 1 illustrates the conceptual model of the project. We measured outcomes through a comparison of pretest and posttest results, qualitative analysis of issues discussed by the women during meetings, and concordance analysis (Kendall's W) of the participants' rankings of most important reasons for attending the clinic.

METHODS

CONTACTING POTENTIAL PARTICIPANTS

We used three methods to identify the potential population. First, the project's interpreter and cultural adviser listed all the adult Vietnamese women thought to be living in Olmsted County. Second, we searched local telephone directories for surnames identified by the American Refugee Committee as Vietnamese. Finally, we searched the Mayo Clinic patient registry to locate women aged 18 years or older with Vietnamese surnames. As shown in Figure 2, we identified the names of 537 adult Vietnamese women potentially residing in Olmsted County.

The interpreter contacted the potential participants by telephone. On average, the interpreter spent 30 minutes per call, providing reassurance and answering questions about the project (e.g., Will men be at the meeting? Will there be an examination that night? What will this cost?). A total of 175 women were successfully contacted, with 73% responding positively to the invitation to attend the community meetings (see Figure 2). However, of the 127 women who wanted to attend, 29% could not because of schedule conflicts. Among the 362 women not contacted, 72% had no telephone, had a wrong telephone number listed, or did not answer the telephone.

EDUCATIONAL MEETINGS

We invited the women to participate in one of 12 community meetings held at a local public school during the evening. The meetings were limited to 15 participants. The two-hour meetings were conducted by the first author and the project's interpreter (a woman who had been trained as a nurse in Vietnam). We attempted to create a culturally sensitive environment; only women were present at the meetings, and Vietnamese egg rolls, tea, and fruit were served. Free transportation was provided, and a Vietnamese woman accompanied the driver to serve as greeter and interpreter. The greeter also provided child care during the meetings.

We used a pretest and posttest to assess basic knowledge about cancer and cancer screening, gather demographic data, and measure the effectiveness of the educational intervention. The meeting consisted of a lecture and video* on breast and cervical cancer and a demonstration of breast self-examination. Instructional materials, in both Vietnamese and simple English, were given to the participants. In addition, an open discussion of women's health issues and concerns about "difficulties going to the doctor" was conducted. At the conclusion of the community meeting, the women were invited to attend clinics for breast and cervical cancer screening.

SCREENING CLINICS

We organized the afternoon screening clinics as small group appointments for three to six participants following the recommendations of a previous study.³ To minimize barriers described both in the literature and by the community meeting participants, free transportation was provided, only female providers participated in the examinations, and the same interpreter translated at the clinic as at the meetings.

RESULTS

EDUCATIONAL MEETINGS

The mean age of the women attending the educational meetings was 37 years (range=18 to 71 years). The median length of residence in the United States was four years. Forty-seven percent of the women were employed, and 87% were covered by health insur-

*The video was produced by the Mayo Clinic in cooperation with the American Cancer Society. It is available free of charge in Vietnamese (#2528.05) or Cambodian (#2527.05). Contact the ACS library, 612/925-2772, ext. 1235.

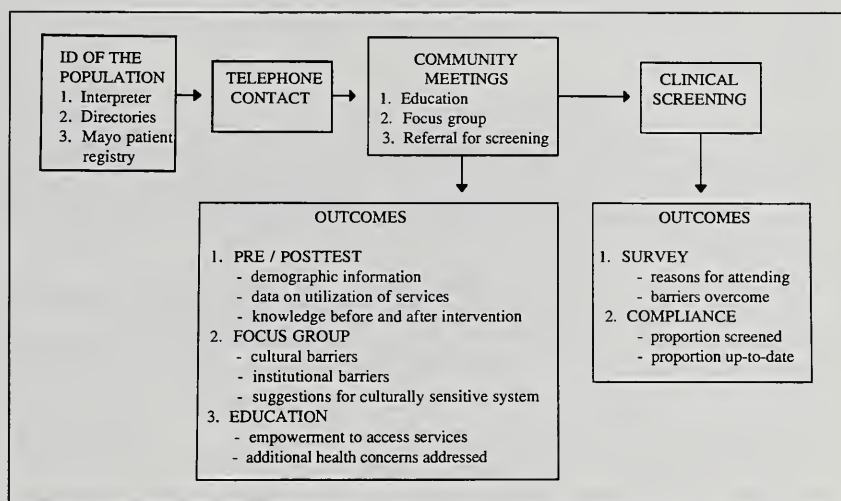


Figure 1—Conceptual model of the Vietnamese women's cancer screening project

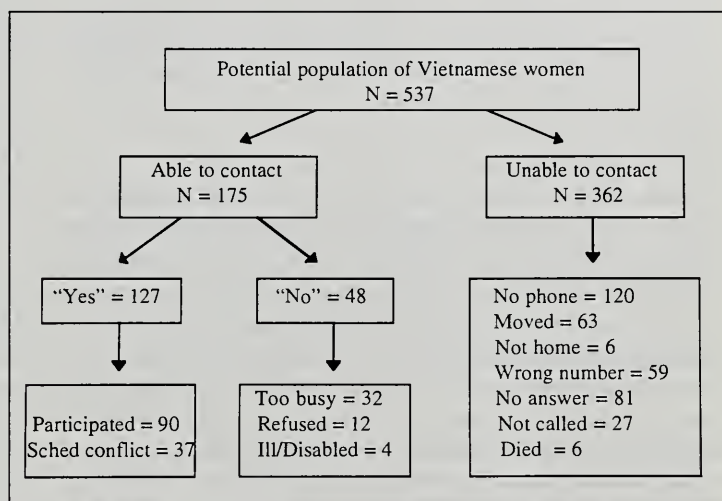


Figure 2—Contact of the population by telephone

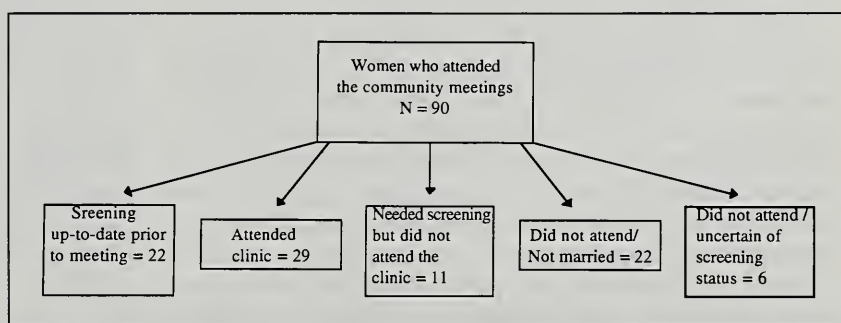


Figure 3—Response to the screening clinics

ance (private and public). More than half of the women rated their overall health as "fair" (53%) or "poor" (10%), and only 18% considered their health to be excellent or very good.

The comparison of pretests and posttests reflected changes in attitudes toward cancer and cancer screening at the end of the meeting. In the pretest, 26% of the women thought cancer was contagious, compared with 4% in the posttest ($p>.05$). Similarly, the pretest showed 63% of the women thought the Pap smear

might take away their virginity, versus 10% in the posttest ($p>.05$).

SCREENING CLINICS

The women's response to the screening clinics is presented in Figure 3 together with their self-reported screening status for Pap smears and mammograms. All 22 unmarried women chose not to attend the clinics. Thus, 68 married women became the target group for screening. At the end of the project, 75% of the married women were up-to-date with their breast and cervical cancer screening according to the American Cancer Society guidelines; this includes 22 women who had completed the screening prior to the community meetings.

The 29 women attending the clinics were asked to rank the top five reasons from a list of 10 choices for participating. The women concurred ($p<.001$) with the following rankings: 1) the guaranteed presence of a female interpreter, 2) presence of a female clinician, 3) free transportation, 4) prearranged appointments, and 5) availability of a person to guide them through the building.

DISCUSSION

This community intervention project encompassed measures to overcome linguistic, cultural, and economic barriers to preventive health services. The interventions included telephone calls by a respected Vietnamese community leader, female interpreters and clinicians, free transportation, ethnic food, pre-arranged small group clinical appointments, funding for the uninsured, and child care. The educational meetings and cancer screening clinics were well received by the Vietnamese women. Those who came with fear and skepticism left with appreciation and new knowledge. Women who decided to attend the clinics encouraged women who were reluctant to attend.

The results clearly support the findings of previous studies of Asian-American women.¹⁻⁴ The main barriers continue to be the lack of female interpreters and clinicians to discuss women's health issues. The participants of this study stated that they are uncomfortable having a gynecological exam by a male physician. They were even more wary of having a male interpreter from their tightly knit community present at the exam.

The high response rate for the community educational meetings (73%) demonstrates that Vietnamese women are willing to attend breast and cervical cancer intervention if the services are presented in a culturally acceptable manner. However, unmarried women are unwilling to undergo Pap smears, likely because of a pervasive cultural concern that the Pap smear will take away a woman's virginity. Our findings indicate that small group meetings are considered a safe environment to ask about and discuss intimate health concerns and difficulties in accessing care. Transportation is a notable barrier, since many immigrant women do not drive or own a car, and many have little knowledge about geographic locations and bus routes.

Identifying and contacting the Vietnamese popula-

tion residing in Olmsted County was difficult. In addition to calling by telephone, we recommend alternative strategies be considered to recruit immigrants (e.g., contacting churches, clinics, work sites, and social programs). Financial resources, interpreters, and staff with strategic planning skills are needed to design and coordinate community interventions that are accessible and acceptable to immigrant women.

CONCLUSION

To ensure that recent immigrants benefit from preventive health services, intervention designs must consider individual, cultural, and institutional barriers to accessing care. Health care institutions have become complex organizational settings where appointments are made in a multistep process and services are delivered in maze-like centers. Such an environment increases women's anxiety about communicating in a foreign language and their reluctance to visit health care institutions alone for fear of getting lost. Designating a staff member to handle all appointments and to guide patients through the organization increases the patients' confidence and encourages immigrant women to seek care. Health care providers will be challenged to increase accessibility for immigrants as cultural diversity expands in Minnesota.

MM

ACKNOWLEDGMENTS

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REFERENCES

1. Mo B. Modesty, sexuality, and breast health in Chinese-American women. *West J Med* 1992;157:260-4.
2. Yi JK. Factors associated with cervical cancer screening behavior among Vietnamese women. *J Community Health* 1994;19:189-200.
3. Kelly AW, Fores Chacori MaM, Wollen PC, et al. A program to increase breast and cervical cancer screening for Cambodian women in a Midwestern community. *Mayo Clin Proc* (to be published).
4. Pham CT, McPhee SJ. Knowledge, attitudes, and practices of breast and cervical cancer screening among Vietnamese women. *J Cancer Educ* 1992;7:305-10.

Providing Culturally Competent Health Care to Hmong Patients

The Minnesota Center for Health Care Ethics is promoting cross-cultural understanding among health professionals to help patients of diverse cultures get the care they need.

Karen G. Gervais, Ph.D.

Bioethics in the United States reflects the values and ethical principles of the dominant culture. Its model for ethically informed health care decision-making is decidedly Western, centered on an individualistic concept of self, patient autonomy, and a rational model of decision-making.

Societal changes affecting health care practice challenge our prevailing bioethical theory and principles. Communities of color bring alternative perspectives on self and community, decision-making, spirituality, causality, and health and illness to health care encounters. The changing face of our society requires that we adjust our bioethical framework and remove the presumption that all health care encounters are unicultural.

To make the benefits of Western medicine available to people of non-Western cultural backgrounds, we must respect values other than our own. We must learn to care for people whose views of the self, family, community, time, causality, and spirituality depart from the temporally bounded, individualistic, and mechanistic perspectives that prevail in Western culture.

Meeting the health care needs of Minnesota's Hmong population is one example of this challenge. Minnesota has the second largest Hmong population in the United States. More than 30,000 Hmong live in the Twin Cities, and secondary migration is bringing many Hmong to Minnesota from other parts of the country—a demographic change that has a profound impact on local health care providers.

The Minnesota Center for Health Care Ethics is striving to promote culturally competent health care for the Hmong and to build a model ethical framework for intercultural health care relationships generally.

DIVERSITY SUMMIT I: HMONG PERSPECTIVES ON CRITICAL CARE

To promote cross-cultural understanding among health care professionals, the Minnesota Center for Health Care Ethics conceived the idea of an annual conference called the Diversity Summit. In 1995, the Minnesota

Center held its first summit, "Hmong Perspectives on Critical Care."

True to its name, the conference provided a "summit"—a special meeting enabling "mainstream" health care providers to learn from representatives of the Hmong community. Hmong participants taught conference attendees about their cultural beliefs and decision-making practices regarding the critically ill and about barriers Hmong patients encounter to obtaining culturally competent care. These barriers include:

- providers' failure to understand the world view, causal understandings, and decision-making customs of the Hmong;
- imposition of Western linguistic and conceptual structures on communication with patients and families;
- discounting of traditional social and spiritual support systems, such as the clan, elders, and shaman;
- disregard of traditional healing practices;
- threat of legal interventions based on Western perceptions of, for example, parental neglect; and
- disregard of attitudes and etiquette concerning interpersonal relationships.

During the conference, panels of Hmong professionals from a number of health care and social services fields discussed Hmong perspectives on critical illness and the communication needs of Hmong patients and families. A shaman and an herbal healer described traditional Hmong health practices, and a young woman talked poignantly about how a clash between Western medicine and Hmong practices affected her relationships with family and community when she sought a kidney transplant.

A video* conveyed through the voice of Hmong patients and families demonstrated difficulties encountered in the Western health care system: the failure of health care professionals to provide adequate explana-

*"Western Medicine Through Hmong Voices" (video). Copies can be purchased from the Minnesota Center for Health Care Ethics by calling Margie Noonan at 612/690-7895.

tions or to seek consent to treatment, providers' mistrust and exclusion of traditional Hmong practices in times of medical crisis and major life transitions, and patients' fear of being experimented on and of legal interventions that would disrupt their relationships with their children. A play[†] presented dialogue between two physicians trying to resolve their frustrations and dilemmas in treating a critically ill child from another culture. The conference closed with performances of Hmong traditional dance, music, and a play retelling Hmong history.

Diversity Summit I grew out of a year-long collaboration between members of the Hmong Community and the Minnesota Center for Health Care Ethics. That collaboration continues in preparation for Diversity Summit II, "Respecting Hmong Beliefs and Practices in Health Care Settings," to be held later this year.

TREATING HMONG PATIENTS: LESSONS LEARNED

A resounding message came from the speakers at Diversity Summit I: *Build trust*. As one of our speakers poignantly stated, "By investing yourself in creating the trust of one Hmong person, you will build the trust of many. The loss of the trust of one will lose the trust of many."

BUILDING PROVIDER-PATIENT RELATIONSHIPS

Conference speakers made concrete suggestions concerning relationship-building with Hmong patients and families. The Hmong appreciate introductions and have an interest in knowing some personal information about their caregiver. Going to a physician is often a last resort for them; for one, they rely on their own healing practices (shaman rituals, herbal medicine, and massage). In addition, they fear invasive procedures. Their experiences in Laos and as refugees have made many Hmong understandably distrustful of authority. They are particularly concerned that they may be subjects of medical experiments.

For these reasons, relationship-building is critical, and providers should explain every test or treatment option in detail and give clear justification. It is important for providers to speak with respect, to smile, to know some words of Hmong, and to ask open-ended questions like, "What brought you here today?" The Hmong believe that bad news given by an authority figure can have the power of a curse. For example, rather than saying, "Your son is dying," physicians should use less direct phrases like, "Your family will have a difficult time in the next week or so."

UNDERSTANDING HMONG BELIEFS AND COMMUNICATING APPROPRIATELY

The Hmong consider the person to be a unity of body and soul. People are considered ill when they can no longer

perform their accustomed roles within the community. The Hmong have a variety of etiological accounts of illness, and their traditional healing practices will vary depending on their beliefs about the cause of an illness. Illness may be the result of spirits, natural imbalances, organic causes, supernatural occurrences, and magic.

Many aspects of body structure and function remain a mystery to the Hmong. Illness, considered a departure or wandering of the soul, requires a shaman to "recall" the soul to its place within the body. This may require bargaining with a spirit; thus, a shaman ritual may involve a practice such as animal sacrifice. When traditional Hmong approaches fail, a Western physician's assistance may be sought. The challenge to the physician is to explain what the disease is, what treatment may correct the problem and why, and what the likelihood of success is. Too many tests and too little rationale will generate suspicion and discomfort. For this reason, it is better for physicians to use tests sparingly, taking diagnosis one step at a time.

Hmong patients might believe in Western medicine, but they do not always agree with its assumptions and methods. Like all patients, they want explanations in terms they can understand. They want to know what a treatment is for, why it is necessary, and why they will not improve without the treatment. Health care providers should offer explanations that do not challenge Hmong concepts. The goal is not to get the Hmong to think as Westerners but to explain Western medicine in terms accessible to the Hmong.

Visible and invisible diseases: The Hmong consider illnesses that have discernible manifestations (like chicken pox) to have organic origins. These outward symptoms indicate that the body's natural balance is disturbed. The Hmong understand the use of healing measures to restore the body's balance, and their herbal medicines are used with this intent.

Communication can be particularly difficult concerning diseases that lack outwardly discernible signs, such as infectious diseases like tuberculosis, or unseen structural or functional abnormalities. When lab tests confirm a condition the patient cannot see, the physician might compare for the patient and family the abnormal results with a healthy person's lab results. If a child has a heart murmur and needs treatment, the physician can ask the parents to listen to a healthy heartbeat and compare it with their child's heartbeat. Another family or patient who has faced the same problem may be able to help the family understand the situation. Physicians must use creativity to demystify the body and its inner processes, utilize Hmong etiological perspectives to aid in communication, and allow Hmong patients the opportunity to use traditional healing practices in the care plan.

Surgery and anesthesia: Surgery and anesthesia are particularly troubling to the Hmong. Because the Hmong believe the person is a unity of body and soul, they fear procedures that alter the body. Such procedures may compromise the soul's well-being. They are concerned that surgery and anesthesia may negatively affect them in

[†]"Second Opinion" by Timothy Cope. ©1995, Timothy Cope and the Science Museum of Minnesota.

this life and the next, and that the procedures may also adversely affect their family members. Families of patients for whom surgery or another intervention has failed will feel vulnerable to the spirit of the deceased, which may cause trouble for them.

Therefore, it is important for the physician to find ways to convey concretely what the surgery involves and why it is expected to improve the patient's health. Hmong patients who receive thorough explanations are more likely to choose surgery to alter disfigurement, improve function, or lengthen life. Because the Hmong fear that the soul will wander when anesthesia induces an unnatural deep sleep, it is important for physicians to offer alternatives to general anesthesia when possible. Patients facing difficult procedures are aided by the presence of family members and others from their community, and physicians should enable this.

As these examples show, a good provider-patient relationship requires time, attention to cultural differences, a commitment to developing creative approaches to patient education, and an appreciation of the role of customary healing practices. A physician's assurance that traditional Hmong healing practices may continue in tandem with Western medicine is not only a sign of respect, but also a great reassurance to patients and families.

ACCOMMODATING HMONG DECISION-MAKING PRACTICES

An ethically informed health care decision is based on an understanding of the physical, psychological, familial, social, spiritual, and economic consequences of the decision and is consistent with the values, beliefs, and desires of the patient (and/or the patient's family). Patients and families must make health care decisions consistent with their deepest understandings of the meaning and value of life, otherwise they will be at odds with themselves in potentially harmful ways.

Providers should try to identify Hmong patients' preferred decision-making practices. They can take steps to determine who should be included in making a decision and, thus, who should be present when the physician explains the patient's diagnosis, prognosis, and possible treatment options.

The Western decision-making model focuses on the autonomous patient who decides about health care interventions on the basis of personally held values and beliefs. This model does not enable Hmong approaches to decision-making.

The Hmong person is a communal person, constituted and sustained by communal ties to family, clan, lineage, and ancestors. Thus, decision-making is a common, not an individual, act. In times of medical crisis, the Hmong confront a Western medical structure that is individualistic and, for them, socially isolating. Western patient autonomy is Hmong isolation.

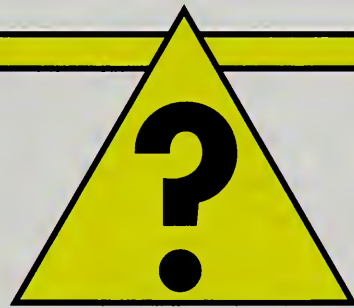
We need to address the needs of Hmong patients as communal people. This requires a sensitivity to their traditional decision-making structures and means that informed consent procedures should be adjusted to the

patient's values. If the patient values decision-making by the extended family, then the consultation must include family members, and the patient and family should be allowed sufficient time for reflection. Conversely, physicians must be aware that some Hmong people may have adopted a more Western perspective on health, disease, and autonomous decision-making.

CULTURALLY COMPETENT HEALTH CARE

The field of bioethics has the opportunity to create an intercultural health care ethic that answers the question, "In what ways must cultural difference be addressed to promote effective health care relationships and authentic health care decisions by persons of diverse cultures?" An intercultural health care ethic will elaborate the conditions essential to cultural respect, conditions that enable ethically informed decision-making. Work with specific communities of color must then provide concrete direction to health care professionals in implementing that ethic—the process the Minnesota Center for Health Care Ethics is currently engaged in with the Hmong community. In this way, bioethics will contribute to the evolving of practices that will enable the American "melting pot" to be a mosaic of intercultural exchange, rather than a source of confusion for the many cultures that increasingly enrich and challenge Western ways. MM

Karen Gervais is director of the Minnesota Center for Health Care Ethics, an academic, clinical, and policy consortium based in Minneapolis.



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People and Places Making Medical News

People

'U' Names New Academic Health Center Provost

Frank Cerra, M.D., dean of the University of Minnesota Medical School for the past year, has been named provost of the university's Academic Health Center. He assumed the position April 15. Cerra replaces William Brody, M.D., who has been named president of the Johns Hopkins University in Baltimore. Brody will serve as special assistant to University of Minnesota president Nils Hasselmo until he departs for Johns Hopkins, no later than September 1.

Cerra will continue to serve as dean of the medical school until the university finds a replacement. As provost, he plans to continue the momentum to "re-engineer" the university's Academic Health Center, which includes the schools of medicine, dentistry, nursing, public health, pharmacy, and veterinary medicine.

HCMC Names Crimmins Deputy Medical Director

Hennepin County Medical Center has appointed Timothy Crimmins, M.D., deputy medical director. He replaces Chuck Oberg, M.D., who has become Hennepin Faculty Associates senior vice president for medical affairs.

In his new position, Crimmins, who is an emergency medicine physician and chair of the MMA Board of Trustees, sees himself playing two important roles. "I see myself as a liaison with the community, the Minnesota Legislature, and other groups and forums, to make them aware of our role and our capabilities. I also see myself as a liaison between HCMC and our physicians, to help foster our strong relationship and common

visions," Crimmins told the HCMC *Scanner* newspaper.

Distinguished Service Award

Melvin E. Sigel, M.D., a clinical professor in the Department of Otolaryngology at the University of Minnesota, received the Distinguished Service Award from the Federation of State Medical Boards of the United States. He was recognized for his outstanding leadership and tireless efforts on behalf of the federation and the field of medical licensure and discipline.

Sigel's association with the federation began in 1984, when he was appointed to the Minnesota Board of Medical Examiners. He was president of the Minnesota board in 1988 and 1991. He also served on the federation's board of directors from 1988 to 1994 and has contributed to numerous committees.

The Federation of State Medical Boards of the United States is a national nonprofit organization that represents the state medical licensing and disciplinary boards in all 50 states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.

U of M Names Cancer Prevention Chair

Stephen S. Hecht, Ph.D., an internationally recognized expert in how substances in tobacco cause cancer, has been appointed to the Winston and Maxine Wallin Land Grant Chair in Cancer Prevention at the University of Minnesota Cancer Center. Since 1989, he has been director of research for the American Health Foundation, a New York-based nonprofit dedicated to cancer prevention. He assumes his new position this month.

Hecht's expertise will complement current prevention activities in breast, childhood, lung, ovarian,

and colon cancers, as well as smoking cessation, said John Kersey, M.D., director of the Cancer Center.

"I think this is a fantastic opportunity to work with other investigators to strengthen the University of Minnesota Cancer Center's prevention program," says Hecht, whose research has focused on two classes of carcinogens found in foods and tobacco—nitrosamines and polynuclear aromatic hydrocarbons.

AAR Recognizes Outstanding Research Achievements

A Minnesotan is among six of the nation's leading cancer investigators honored by the American Association for Cancer Research at its 87th Annual Meeting in Washington, D.C., last month.

The University of Minnesota's Lee W. Wattenberg, M.D., received the fifth annual American Cancer Society Award for excellence in cancer epidemiology and prevention. He is special associate director for chemoprevention at the University of Minnesota Cancer Center and professor of laboratory medicine and pathology at the university's Medical School in Minneapolis. The award recognizes his pioneering studies, which have laid the foundation for much of today's research in chemoprevention.

Places

Reproductive Clinic Relocating to North Memorial

The Midwest Center for Reproductive Health, P.A., will relocate its clinical office and laboratory facilities to North Memorial Medical Center in Robbinsdale in August.

"This is an exciting time for our program," said Randle S. Corfman, Ph.D., M.D., co-founder

of the center. "We have an opportunity to create a state-of-the-art laboratory facility at North Memorial, which allows us to continue to provide the best care possible to our patients."

The center was established in 1992 by Corfman, a reproductive endocrinologist, and G. David Ball, laboratory director, both formerly with the Mayo Clinic.

HealthEast Opens New Clinic in Macalester/Groveland

HealthEast Clinics has opened a new family practice clinic in the Macalester/Groveland neighborhood of St. Paul offering general family health care, including services for women and older adults.

The 5,700-square-foot facility located at 45 North Snelling Avenue has 12 exam rooms, a minor procedure room, and an x-ray lab. The expansion was prompted by the heavy demand for additional patient services at the Highland Family Physician clinics.

HealthEast has 15 physician clinics in 21 locations around the East Metro area.

Fairview Opens Highland Park Clinic

The new Fairview Highland Park Clinic opened last month in the Plaza on Parkway building located at 2145 Ford Parkway in St. Paul. The \$1 million, 7,000-square-foot family practice clinic offers a number of health services, including care for infants, children, adults, and older adults, and home nurse visits for moms and newborns. Starting in July, ob/gyn services and on-site mammography for breast cancer screening will be available to female patients. The clinic is staffed by physicians Robert Bundt, M.D., medical director; Teresa Quinn, M.D.; and Adam Sorscher, M.D.

Fairview Retail Pharmacy and the Institute for Athletic Medicine will join the Fairview Highland Park Clinic at the Plaza on Parkway building this summer. The institute, a service of Fairview and

North Memorial Medical Center, provides physical therapy, sports medicine, and general rehabilitation.

New Cokato Medical Clinic Opens

Cokato Medical Clinic, part of the Allina Health System, opened in March. The staff of this 8,000-square-foot clinic, located off Highway 12 on 110 Olsen Boulevard, includes five physicians specializing in family practice, internal medicine, and pediatrics. A sixth physician is scheduled to join the staff in September.

The clinic offers specialized medical services, including cardiology, obstetrics and gynecology, orthopedics, low-back care, gastroenterology, dermatology, and ear, nose, and throat care.

Fairview Creates Partnership With Long-Term Care Groups

Fairview Health System, Fairview Physician Associates (FPA), and 14 metro area long-term care organizations have united to form Fairview Partners, a provider-based group focused on improving the quality of health care services for nursing home residents.

"We have created a model and are revising the health care system incentives to use the nursing home more, rather than the hospital, as the primary place to provide resident care. This promises a better quality of care and a more effective use of health care dollars," said Jeanne Lally, Fairview vice president of continuum services.

The start-up costs for this project, which begins June 1, are being funded by a three-year, \$644,212 grant from the Robert Wood Johnson Foundation. An estimated 750 nursing home residents are expected to enroll in the new project over the next three years.

In addition to FPA and the Fairview hospitals, the partners involved are Apple Valley Health Care Center, Augustana Home, Bloomington Good Samaritan

Center, Ebenezer Hall, Ebenezer Luther Hall, Ebenezer Ridges Care Center, Edina Care Center, Friendship Village of Bloomington, Martin Luther Manor, Mount Olivet Careview Home, Richfield Health Center, University Good Samaritan Center, Walker Methodist Health Center, and Walker Southview.

'U' Receives Grant for Spiritual Care

The University of Minnesota Hospital and Clinic has received a \$150,000 grant from the Arthur Vining Davis Foundation to help fund the hospital's Center for Spiritual Care and Healing. The money will be used to complete a new meditation area, plan a spiritual care and healing curriculum, bring in speakers for workshops and conferences, and purchase resource materials.

"This support will help us create a center that can be a model for other health care delivery systems and pastoral education programs as we demonstrate how spiritual care and healing can be incorporated in today's health care environment," said center administrator Mary Jo Kreitzer.

Minnesota Monitoring Mad Cow Disease

Minnesota is among four states participating in a national surveillance of Creutzfeldt-Jakob disease, a fatal neurological illness in humans that has a possible link to bovine spongiform encephalopathy, known as mad cow disease.

An outbreak in Britain of the cattle version of the disease began in 1986 and peaked in the early 1990s. Physicians in Britain believe that the disease may have been transmitted to humans. Ten people in Britain, all under age 42, have recently died of an apparent variant of CJ disease, possibly tied to mad cow disease. CJ disease strikes only about one in a million people annually, usually late in life.

The Minnesota Department of Health was chosen to participate in intensified monitoring because it has in place a federally sponsored

system for monitoring emerging infectious diseases. Other states participating in the surveillance are California, Connecticut, and Oregon.

Socioeconomics

BCBSM Adds Benefits, Maintains Rates

Blue Cross and Blue Shield of Minnesota is increasing the benefits in its Aware Care health plan while keeping rates the same—the third straight year of stable rates. Aware Care, which caters to the self-employed and other people who

want coverage usually available to groups, was able to maintain rates by adding new people to the pool, managing administrative costs, and working with doctors, said BCBSM spokesperson Greg Bury in a *St. Paul Pioneer Press* article. The plan covers about 123,000 people.

Effective last month, the plan covers routine preventive services, including immunizations, physicals, and hearing exams. The plan will now cover 80 percent of maternity services, up from 50 percent.

Aetna Buys U.S. Healthcare Inc.

Aetna Life and Casualty Co., based in Hartford, Connecticut, is buying

U.S. Healthcare Inc., based in Blue Bell, Pennsylvania. The \$8.9 billion deal creates the nation's largest health benefits provider, covering such services as life, health, and disability insurance; prescriptions; mental health, vision, and dental care for a combined total of 23 million people nationwide. Of those, 14 million have full-scale medical coverage.

The combined company will retain the name Aetna, but will be managed similarly to U.S. Healthcare, which is more profitable. Aetna earned \$252 million last year on \$13 billion in revenues, while U.S. Healthcare earned \$380 million on \$3.6 billion in revenue. By reducing operating expenses and adding new revenues, Aetna expects the purchase to add \$300 million in profits within 18 months.

Rates, Trends, Data

Percentage of State's Uninsured Drops

The percentage of uninsured Minnesotans has dropped from 6.1 percent in 1990 to 5.5 percent in 1995, according to a University of Minnesota study. The MinnesotaCare program is being credited for the low percentage of uninsured. Nationally, the percentage of uninsured has been rising.

The state Human Services Department last October credited MinnesotaCare for saving the state and federal governments more than \$26 million each year because of lower welfare costs. The department estimated that the program has allowed 8,253 residents to purchase affordable health insurance, take low-paying jobs, and drop from the Aid to Families With Dependent Children program.

To assess the state's current uninsured rate, university researchers called 11,500 randomly selected Minnesotans between October and February and asked them whether they were insured and what the status of their coverage had been during the previous 12 months.

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The researchers held longer interviews with 1,600 of the respondents.

The study revealed that nearly 9 percent of the respondents did not have health insurance at some time during the 12-month period, but only 3.8 percent were without coverage for the entire year, down from 4.5 percent in 1990. In addition, 67 percent of Minnesotans were covered by group policies through employers or unions, a slight increase from 1990. Meanwhile, the overall number of Minnesotans who purchased individual policies dropped from 9.5 percent in 1990 to 4.6 percent in 1995. Individuals covered by public policies, such as Medicaid, increased from 19 percent in 1990 to 22 percent in 1995.

An estimated 43.4 million Americans currently do not have health insurance. The number of uninsured continues to increase by 1.2 million each year, boosting the nation's uninsured rate from 13.9 percent in 1990 to 15.2 percent in 1994, according to experts.

Homicide, Suicide Are Top Killers of Hennepin County Youth

Hennepin County youth are dying from homicides and suicides at rates far higher than other causes of death, according to a five-year study by the county's Community Health Department. From 1989 through 1993, 54 kids died from homicide and 45 from suicide, compared with 28 deaths from motor vehicle crashes, the next most common cause of injury deaths among Hennepin County youth.

The report shows that more Hennepin County youth, from infants to 19-year-olds, die from intentional and unintentional injuries than from all childhood diseases and other causes combined. Of 371 deaths during the study, 56 percent were from injuries. Young children were most often killed by abuse, and older children most often by guns. Among teens aged 15 to 19,

77 percent were killed with guns. The report is intended to help the county develop programs and policies to keep children safer.

Nationally, the Children's Defense Fund reported that gunfire is the second-leading cause of death among U.S. children aged 10 to 19. Firearm deaths are increasing faster among youth than any other age group. According to data from the National Center for Health Statistics, the number of firearm deaths to youth under age 20 increased 7 percent in 1993, from 5,379 in 1992 to 5,751 in 1993.

More Minnesota Kids Are Poor, Violent, and Abused

Minnesota's children are becoming poorer, are more often physically and sexually abused, and are committing more violent crimes. Meanwhile, their health, school dropout rates, and teen pregnancy rates remain the same, according to a report by the Children's Defense Fund—Minnesota and Congregations in Community (formerly Congregations Concerned for Children.)

According to the report, 1,767 children were arrested for violent crimes in 1993, up from 961 in 1986. And in 1993 more than 125,000 Minnesota children (11 percent) received Aid to Families With Dependent Children, compared with 115,500 in 1991 and 99,000 in 1986. Students eligible for free or reduced-price school lunches increased from 198,000 in 1991 to 224,000 in 1993.

On a positive note, violent deaths and low birthweights have stabilized, and the percentage of black children born at low birthweights has decreased from 12.2 percent in 1991 to 9.9 percent in 1993.

In addition, the percentage of students dropping out of school held steady from 1991 to 1993, with 3.4 percent dropping out in 1993.

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HMO Enrollment Up 23 Percent

Enrollment in Minnesota's HMOs increased 23 percent in 1995. The approximately 380,000 new enrollees bring the state's total HMO membership to more than 2 million—about 45 percent of Minnesota's population, according to the Minnesota Council of HMOs.

Revenues increased by about 11 percent, to just over \$3 billion, and profits were up by about 2 percent. Premiums increased by only 0.9 percent from 1994.

Minnesota's HMOs spend an average of 9.23 percent of premium revenues on administrative costs. The highest last year was Mayo Health Plan, at 14.08 percent, and the lowest was HealthPartners, at 7.78 percent.

Medica is the state's largest HMO, with 950,025 members and revenues of \$1.39 billion. Next is HealthPartners, with 660,274



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members and revenues of \$1.08 billion, followed by Blue Plus, with 333,169 members and revenues of \$393.2 million, and UCare Minnesota, with 39,086 members and revenues of \$87.7 million.

Innovations

FDA Approves New Test for Recurring Breast Cancer

Based on trials at the University of Minnesota and four other institutions, the U.S. Food and Drug Administration has approved a new blood test that can detect recurring breast cancer. The test, Truquant BR RIA, might improve the cure rate for breast cancer, according to David Kiang, M.D., Ph.D., a University of Minnesota cancer specialist and principal investigator in the trial. He said physicians can use the test to check periodically for recurring breast cancer and begin chemotherapy if the blood test is positive. The test

allows two to six months more lead time than standard follow-up to begin treatment, he said in a Twin Cities *Star Tribune* article.

Kiang said that the University of Minnesota trial found that if the test showed no elevation in a protein shed by cancer cells, there was no recurrence 93 percent of the time. If the test was positive, a tumor was present in 80 percent to 85 percent of cases. The drug's manufacturer said a positive test indicates cancer recurrence 99 percent of the time. The discrepancy is from measuring different levels of the protein.

The FDA approved the test for women with Stage II and III breast cancer. Other sites involved in the drug trial were the M.D. Anderson Cancer Center in Houston; the University of California, Los Angeles; Johns Hopkins University in Baltimore; and Bowman Gray School of Medicine in Winston-Salem, North Carolina.

For more information about the new breast cancer test, the manufacturer has set up a toll-free hotline for physicians and patients: 800/556-1275.

'U' Researchers Testing Promising Prostate Cancer Treatment

University of Minnesota researchers are testing on mice a promising new way to kill prostate cancer cells without damaging other organs and tissue, according to Akhouri Sinha, a professor in genetics and cell biology at the university and a research scientist at the Minneapolis VA Medical Center.

"I have worked for 25 years on prostate cancer and have never been this excited in my life," he said in a *St. Paul Pioneer Press* article. He notes that researchers have only begun to test the treatment on mice.

The process, which Sinha explained to other researchers at a recent prostate cancer seminar in Washington, D.C., involves piggybacking a powerful anticancer drug on a PSA antibody (created by researchers) that carries the drug

directly to cancer cells.

Sinha said the treatment, if successful, will allow doctors to treat patients with chemotherapy doses 10 to 20 times less potent than current options, reducing the side effects normally associated with chemotherapy. The treatment will also eliminate the impotence and incontinence associated with currently available prostate cancer treatments.

Medical Research

.....

Hodgkin Therapy Increases Risk of Other Cancer

Young girls who are treated for Hodgkin disease are 75 times more likely than adult women to develop breast cancer, according to a study published in the March 21 *New England Journal of Medicine*. The risk was highest for girls treated between the ages of 10 and 16, said Smita Bhatia, M.D., M.P.H., a University of Minnesota pediatric oncologist who helped lead the international study. The study also found that boys and girls successfully treated for Hodgkin disease are 18 times more likely to develop other forms of cancer in late childhood or early adulthood.

Alcoholics Die Mainly from Tobacco-Related Causes

A retrospective study of alcoholics by Mayo Clinic shows that 50.9 percent of those who died succumbed to tobacco-related diseases, such as cardiovascular disease and cancer. A smaller number, 34.1 percent, died from alcohol-related causes, such as chronic liver disease and cirrhosis, according to an article in the April 10 *Journal of the American Medical Association*.

"The prevalence of smoking among substance abusers is two to three times that of the general population, and alcoholics may constitute a quarter of all smokers," write the authors. They note that smoking cessation is given little attention in most alcohol treatment programs.

In the study, Mayo's Richard

D. Hurt, M.D., and colleagues analyzed records of 845 Olmsted County residents who were admitted to an inpatient addiction program from 1972 to 1983. They found that 222 of the people had died, and they located death records for 214 (88 percent of whom had been tobacco users).

Women Less Likely to be Treated With 'Clot-Busters'

Women who arrive in coronary care units with chest pain are less likely than men with similar symptoms to be treated with clot-busting drugs, according to a University of Minnesota study. Physicians often believe women are unlikely to suffer heart attacks and tend to look for other causes for chest pain, said Russell Luepker, M.D., co-author of the study and chair of the Division of Epidemiology at the university's School of Public Health. The study was presented at the American Medical Association's cardiovascular disease epidemiology and prevention conference in San Francisco.

The researchers reviewed the medical charts of 1,163 patients (32 percent of them women) who came to the coronary care units of six unnamed Twin Cities hospitals between 1990 and 1993. All were treated for acute heart attacks. Raw data show the men were about twice as likely to be given the clot-busting drugs. After making statistical adjustments to account for other reasons the women may not have received the drug treatment, men were still given clot-busters 40 percent more often than women.

Fewer Twin Cities Dying of Heart Disease

Age-adjusted death rates from coronary heart disease decreased 25 percent in the Twin Cities between 1985 and 1990 and continued a similar decline through 1994, according to a University of Minnesota study published in the April 4 *New England Journal of Medicine*. The authors attribute the decline to healthier diets, less smoking, increased aspirin use, and

better medical care.

The study, led by Paul McGovern, Ph.D., associate professor of epidemiology at the University of Minnesota, included residents of the seven-county metro area between ages 30 and 74. Researchers examined hospital discharge records and death certificates to determine how many patients had been treated for and died of heart attacks.

McGovern said the number of men who died from heart attacks before reaching a hospital decreased from 627 in 1985 to 575 in 1990. The number of women who died dropped from 226 in 1985 to 176 in 1990. The number of men who died of heart attacks in a hospital fell from 446 in 1985 to 284 in 1990. For women, the number decreased from 208 to 165.

The drop in death rates is even larger than the figures suggest because the number of Twin Cities in the age group studied increased about 15 percent during the study period. MM

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Chester Anderson, M.D.
University of Minnesota, 1945
Born: 1920, Died: Feb. 28, 1996

Frank Shaleen Babb, M.D.
Univ. of Western Ontario, 1938
Born: 1913, Died: July 27, 1995

Hugo L. Bair, M.D.
Harvard Medical School, 1929
Born: 1904, Notified: Aug. 1995

J. Gordon Beaton, M.D.
University of Minnesota, 1943
Born: 1915, Died: Aug. 19, 1995

Harold G. Benjamin, M.D.
University of Minnesota, 1934
Born: 1907, Died: Jan. 9, 1996

Bienvenido Briones, M.D.
University of Santo Thomas, 1955
Born: 1930, Died: Nov. 23, 1995

Haddon Carryer, M.D.
Northwestern University, 1939
Born: 1914, Died: Nov. 29, 1995

Bruce Clayton, M.D.
University of Tennessee, 1959
Born: 1928, Died: Nov. 9, 1995

Colleen Counihan, M.D.
University of Wisconsin, 1977
Born: 1951, Died: March 20, 1995

Russell Cox, M.D.
Creighton University, 1946
Born: 1920, Died: April 26, 1995

Edward V. Davis, M.D.
University of Nebraska, 1933
Born: 1909, Notified: Jan. 1996

Robert C. Diercks, M.D.
University of Minnesota, 1967
Born: 1941, Died: Nov. 21, 1995

Mark Donaldson, M.D.
University of Minnesota, 1979
Born: 1952, Died: June 2, 1995

Bernard Flynn, M.D.
Loyola University, 1943
Born: 1917, Died: Sept. 13, 1995

Rene Fortier, M.D.
University of Minnesota, 1943
Born: 1918, Died: July 27, 1995

Jackson R. Galloway, M.D.
Louisiana State University, 1955
Born: 1930, Died: Sept. 4, 1995

Norbert O. Hanson, M.D.
University of Minnesota, 1942
Born: 1916, Notified: May 1995

John Harris, M.D.
University of Oregon, 1950
Born: 1913, Died: May 10, 1995

Donald Hauser, M.D.
University of Minnesota, 1946
Born: 1922, Died: Jan. 10, 1996

Stanton Hirsh, M.D.
University of Minnesota, 1946
Born: 1922, Died: Aug. 21, 1995

Allen G. Janecky, M.D.
University of Minnesota, 1943
Born: 1916, Notified: Jan. 1996

C. Percy Johnson, M.D.
University of Minnesota, 1936
Born: 1906, Died: Sept. 26, 1995

Arnold Joseph, M.D.
University of Minnesota, 1956
Born: 1925, Died: Feb. 10, 1996

John Patrick Kelly, M.D.
University of Minnesota, 1942
Born: 1914, Died: April 27, 1995

Douglas R. Kusske, M.D.
University of Minnesota, 1944
Born: 1918, Notified: Oct. 1995

James J. LeClaire, M.D.
Mayo Medical School, 1981
Born: 1954, Died: Jan. 23, 1996

William J. Lick, M.D.
University of Minnesota, 1943
Born: 1917, Died: Oct. 5, 1995

Robert C. Matyas, M.D.
St. Louis University, 1980
Born: 1949, Died: May 19, 1995

Nick Mensheba, M.D.
Ludwig Maximilliams, Germany, '49
Born: 1922, Died: Nov. 9, 1995

J.C. Miller, M.D.
University of Minnesota, 1931
Born: 1906, Died: Feb. 1, 1996

Stephen D. Mills, M.D.
Columbia University, 1930
Born: 1906, Died: Dec. 27, 1995

Elisabeth M. Murray, M.D.
University of Minnesota, 1931
Born: 1904, Died: June 11, 1995

Donald Navratil, M.D.
University of Minnesota, 1943
Born: 1911, Died: Feb. 2, 1996

Maynard C. Nelson, M.D.
University of Minnesota, 1932
Born: 1907, Died: Feb. 7, 1996

Lawren B. Nessel, M.D.
University of Minnesota, 1943
Born: 1909, Notified: Jan. 1996

Rolland A. Olson, M.D.
Loma Linda University, 1945
Born: 1941, Died: Sept. 23, 1995

Charles Rea, M.D.

University of Minnesota, 1931
Born: 1908, Died: Sept. 24, 1995



John J. Regan Sr., M.D.

University of Minnesota, 1944
Born: 1916, Died: Sept. 17, 1995



Harry Rogers, M.D.

Washington University, 1965
Born: 1941, Died: Feb. 26, 1996



Richard Montgomery Shick, M.D.

University of Michigan, 1935
Born: 1909, Died: Jan. 30, 1996



Maurice L. Straus, M.D.

University of Michigan, 1935
Born: 1907, Died: June 6, 1995



Stuart Thorson, M.D.

University of Minnesota, 1946
Born: 1922, Died: Aug. 22, 1995



Cecil A. Warren, M.D.

University of Minnesota, 1928
Born: 1905, Died: Jan. 2, 1996



Virgil A. Watson, M.D.

St. Louis University, 1949
Born: 1922, Died: Aug. 30, 1995



Walter B. Wells, M.D.

University of Minnesota, 1932
Born: 1908, Notified: July 1995



Edwin Wohlrabe, M.D.

University of Minnesota, 1925
Born: 1899, Notified: Nov. 1995



Henry Yue, M.D.

Far Eastern Univ., Manila, 1977
Born: 1942, Died: Feb. 12, 1996



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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

MAY 1996

May 9-10 **Minnesota Orthopaedic Society 13th Annual Meeting** Minnesota Orthopaedic Society; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Jennifer Stendahl, MOS, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/362-3737.

May 17-18 **Allina Pregnancy Care Initiative** Allina Health System; Radisson South, Bloomington, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

May 17-18 **Using Computers to Help Manage Clinical Information** American College of Physicians and Allina Health System; Earle Brown Continuing Education Center, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

May 30-June 1 **Management Strategies in Hematological Oncology** Mayo Medical Laboratories; Lake Louise, Alberta, Canada. CONTACT: Julie McAdams, Mayo Medical Laboratories, Hilton 360, Rochester, MN 55905; 800/533-1710.

JUNE 1996

June 12-15 **Sixtieth Annual Course on Advances in Trauma and Critical Care Surgery** Department of Surgery, University of Minnesota Medical School; University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 13-15 **Minimally Invasive Coronary Bypass Surgery Symposium** Minneapolis Heart Institute Foundation; Hyatt Regency, Minneapolis, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

June 17-21 **Summer Institute 1996: Optimizing Health for Older Persons—Practical Strategies** Minnesota Chair in Long-Term Care and Aging, MAGEC, and University of Minnesota Center on Aging; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Steve Daniel or Monica Colberg, MAGEC, School of Public Health, University

of Minnesota, Box 197 Mayo, 420 Delaware Street SE, Minneapolis, MN 55455; 612/624-3904.

June 22-23 **The Minnesota Section of the American College of Obstetricians and Gynecologists and the Minnesota Obstetrical and Gynecological Society Spring Meeting** Minnesota Section of ACOG and Minnesota Ob/Gyn Society; Mayo Clinic, Rochester, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875.

June 25-29 **Internal Medicine 1996: Advances and Controversies** Mayo Clinic and the Department of Medicine, Royal College of Surgeons, Ireland Medical School; Dublin, Ireland. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

AUGUST 1996

Aug. 2-3 **Bleeding and Thrombosing Diseases: The Basics and Beyond** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Aug. 8-10 **Third Annual Symposium on Biomedical, Biopharmaceutical, and Clinical Applications of Capillary Electrophoresis** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Aug. 16-17 **Point-of-Care Testing and Phlebotomy** Mayo Medical Laboratories; Swissôtel, Boston, MA. CONTACT: Julie McAdams, Mayo Medical Laboratories, Hilton 360, Rochester, MN 55905; 800/533-1710.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Sue Burmeister, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3216.

Printed Material: **Physicians' Update: Bloodborne Pathogens** Medical Education Group Learning Systems. CONTACT: MEGLS, Internet address: <http://www.cme.edu>; or call 800/547-0308.

Aug. 18-20 **Success With Failure: New Strategies for the Evaluation and Treatment of Congestive Heart Failure** Mayo Foundation; Vail Cascade Hotel & Club, Vail, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Aug. 24-27 **International Symposium on Radioiodine** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

SEPTEMBER 1996

Sept. 9-10 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Sept. 12-14 **Practical Surgical Pathology Conference in Honor of Louis H. Weiland, M.D.** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Kathy Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, Rochester, MN 55905; 800/533-1710.

Sept. 19-20 **Mayo Clinic Update in Hepatology and Liver Transplantation** Mayo Foundation; Hotel Sofitel, Minneapolis, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 19-20 **Sixth Annual Practical Pediatrics Course for the Primary Care Physician** Children's Health Care; Children's Health Care-St. Paul, MN. CONTACT: Mickey Starr, 345 North Smith Avenue, St. Paul, MN 55102; 612/220-6133.

Sept. 29-Oct. 4 **Advances in Diagnostic Radiology and Advanced Radiology Life Support** Mayo Foundation; The Broadmoor Resort, Colorado Springs, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

OCTOBER 1996

Oct. 3-5 **Mayo Vascular Symposium 1996: Advances and Controversies in the Multidisciplinary Management of Vascular Disease** Mayo Clinic and North American Chapter of the International Union of Angiology; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Oct. 4 **Insights and Outlooks '96** St. Paul Heart Clinic; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440; 612/992-3826.

Oct. 6-11 **Laboratory Diagnosis of Fungal Infections** Mayo Medical Laboratories; Portland Marriott at Sable Oaks, South Portland, ME. CONTACT: Kathy Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.



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- North Memorial Health Care, Robbinsdale

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800/999-1875.

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., May 15 for July ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Family Practice, Ob/Gyn to join progressive 14-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*2/96-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

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Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Olmsted Medical Center is seeking BC/BE physicians in the following specialties: emergency medicine and family medicine. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. Positions currently open include emergency room and family medicine departments in Rochester and branch office locations. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes nine branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (5/96-R)

Internal Medicine: The Fergus Falls Medical Group's five-member Internal Medicine Department is seeking a BC/BE general internal medicine physician as well as those with subspecialty training/interest in oncology, pulmonology, and nephrology. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (9/95-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine (oncology, pulmonology, and nephrology), family practice, ophthalmology, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (2/96-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

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Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

For Rent—Black Hills, South Dakota: Modern, luxury geodesic dome on trout stream in the Black Hills National Forest. All conveniences. Sleeps 10-12. April 15 to September 15, \$700 per week. Credit cards accepted. 612/274-5113 or 612/274-5219. 1-5/96

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Considering the Upper Midwest? Contact Jerry Hess, Physician Services, 3600 West 80th Street, Suite 550, Minneapolis, MN 55431; 612/896-3492. Fax: 612/896-3425. 3-6/96



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Community Clinic providing neighborhood-based health care to diverse patient population is seeking a BC/BE family practitioner or internist to join team. Minimal call and hospital coverage. Full or part time. If interested, the position could also include administrative duties of medical director. Call or write Nancy Briggs, Executive Director, North End Medical Center, 135 Manitoba Avenue, St. Paul, MN 55117; 612/489-8021. 2-5/96

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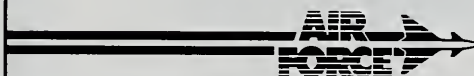
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To apply, please submit a letter of interest, curriculum vitae and three references by 5/31/96 to: Byron Crouse, MD, Family Medicine Search Committee, UMD School of Medicine, 10 University Drive, Duluth, MN 55812 (e-mail: bcrouse@d.unm.edu or phone: 218-726-7916).

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Medical Director

WSCHC has established an opening for a Medical Director as an integral member of our leadership team. The Medical Director has primary responsibility for overseeing provider resources and ensuring a high quality of care and professional satisfaction. Also serves key role in planning, recruitment, quality improvement activities, grants management and community liaison. WSCHC is a federally qualified community health center providing comprehensive medical and dental care for medically underserved populations; includes a family practice residency program. Services provided are bilingual and bicultural; largest populations served include Hispanic and SouthEast Asian (Hmong).

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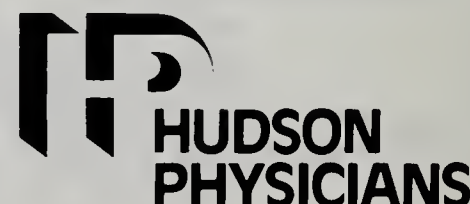
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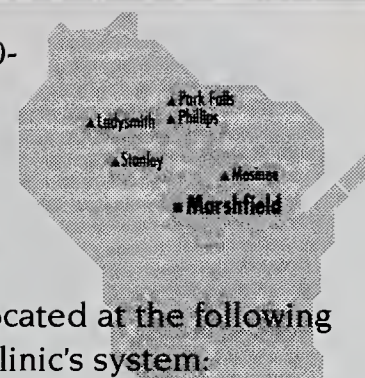
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*1-5/96

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Minnesota Medicine

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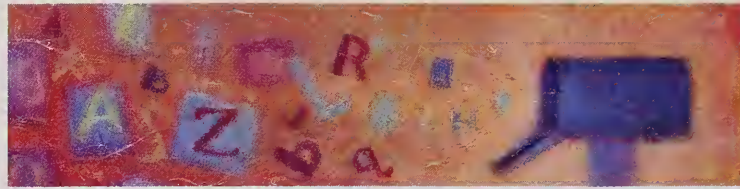
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How Valuable Is Prostate-Specific Antigen Screening?

Inclusion of the Public Health Reports by Joseph Oesterling, M.D., and Del Ohrt, M.D., in the April 1996 *Minnesota Medicine* is a noble attempt to present different viewpoints on the value of prostate-specific antigen (PSA) testing in reducing mortality from prostate cancer. Unfortunately, the two authors represent advocacy groups with inherent vested interests. Such an adversarial approach may be more appropriate in the courtroom than in a medical debate searching for the truth.

As Dr. Oesterling, director of the Michigan Prostate Institute, points out, if the prostate cancer is confined to the prostate gland, radical prostatectomy would be curative. However, there are a great many gland-confined prostate cancers that never cause morbidity or mortality. For those incidental cancers, not removing the gland is also "curative." Dr. Oesterling's approach to improving the yield of PSA screening is to screen even younger men. Because prostate cancer is usually slow growing, diagnoses in young men would likely be more beneficial because of the men's longer life expectancies. Unfortunately, since a majority of men (maybe all men) will develop prostate cancer if they live long enough, more sensitive screening in young men would diagnose an awful lot of cancer that would never act like cancer.

Dr. Oesterling's recommendation would exaggerate that. Since we are unable to reliably distinguish lethal prostate malignancies from those that are incidental, we would be creating an intolerable

situation for a lot of men. "Watchful waiting," a technique advocated by Swedish investigators, is rarely an acceptable option for Americans. Once a cancer is diagnosed, most American men want something done. Although many urologists state that small and well-differentiated tumors in older men are not adequate indication for radical surgery, many men in this situation choose to undergo radical surgery.

Another problem not addressed by Dr. Oesterling is the striking difference seen nationally in therapeutic approaches to treating prostate cancer. A man with prostate cancer living in Alaska or on the West Coast is several times more likely to undergo radical prostatectomy than one who lives in New England. That disparity suggests that we don't really know the value of PSA screening for prostate cancer. Instead of providing answers with long-term clinical trials, urologists prefer to continue promoting radical therapy to treat a disease for which definitive answers are unavailable. The argument that urologists cannot wait for definitive answers because so many men might miss the opportunity for definitive cure is specious; we may just as well be providing dangerous therapy for a disease that would never be a clinical problem to the patient.

I share Dr. Ohrt's conservative approach to PSA screening for prostate cancer. I, too, deplore the fact that eight or 10 years have passed since the controversy began, during which time the appropriate studies could have started. Instead, therapeutic activists prefer to plunge ahead, operating on faith and intuition rather than on scientific evidence. Unfortunately,

as medical director for Blue Cross and Blue Shield of Minnesota, Dr. Ohrt represents a payer with a potential vested interest in controlling subscriber costs. Dr. Ohrt is entitled to his opinion, one which I happen to share, but his argument would carry more weight if he did not represent an insurance company.

Seymour Handler, M.D.
North Pathology Associates, P.L.L.P.
Robbinsdale, Minnesota

Don't Let Managed Care Cost-Cutting Carve Out Psychiatry Entirely

Thank you for the January 1996 *Minnesota Medicine*, which highlights the turmoil of psychiatry in managed care organizations and describes the status and scope of practice for psychoanalysts and psychopharmacologists.

Ironically, while psychiatrists' professional activities are under attack by cost-containing managed care organizations, quality psychiatry offers the medical profession's most effective and efficient interface in the treatment of mental and substance-related disorders.

Psychiatry always entails integrating the "truths" from neuroanatomy, biochemistry, psychology, sociology, politics, and ethics. But is diagnosis in psychiatry really so "slippery," as you claim in your January Editor's Notebook? I challenge the assertion that soft diagnoses and slippery outcomes make guideline development "tricky" in our field.

For four and one-half years I served as associate medical director for mental and substance-related disorders at PreferredOne, during

which time we developed policies and clinical criteria based on the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-III 1980, DSM-III-R 1987, DSM-IV 1994).¹

Psychiatry has taken the lead in developing a multiaxial clinical formulation that allows quantification of biopsychosocial complexity. The DSM Axis I is the primary psychiatric diagnosis based on behavioral criteria; Axis II describes personality disorders, mental retardation, and learning disabilities; Axis III lists and collates comorbid medical conditions (ICD-9 or ICD-10), allowing examination of drug interactions and the impact of other medical diagnoses; Axis IV quantifies and describes external (psychosocial) stressors affecting the patient; and Axis V, the Global Assessment of Function Scale, is based on a standardized criteria set.

Clinical guideline development in psychiatry has been exemplary. Using collated research data from teaching hospitals and centers, the American Psychiatric Association in the past five years has developed five guidelines for major mental disorders, including eating disorders, major depressive disorders, bipolar affective disorders, substance-use disorders (alcohol and opioids), and a recent guideline on the essential elements of a psychiatric evaluation.²

The American Society of Addiction Medicine has taken the lead in developing clinical guidelines for chemical dependency. A major breakthrough occurred in 1991 with the publication of patient placement criteria that allow differentiation on the basis of

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Elusive Managed Care Ethics

Charles R. Meyer, M.D.

How do you solve a problem like Maria?
How do you catch a cloud and pin it down?
How do you find a word that means Maria?
A flibbertijibbet! A will-o'-the-wisp! A clown!
How do you keep a wave upon the sand?
How do you solve a problem like Maria?
How do you hold a moonbeam in your hand?
 —from "The Sound of Music"



"Physicians can't ignore the impact of their decisions outside the exam room."

Managed care ethics? What's that? Cynics would say, like military intelligence or thunderous silences, it's an oxymoron. Believers would contend it guides the actions of even the most behemoth managed care organizations (MCOs). For most of us, it is more like the original will-o'-the-wisp, a phosphorescent glow, the *ignis fatuus*, hovering over the marsh, tough to discern, harder to describe. Courageously, June's *Minnesota Medicine* gets out its infrared goggles and tries to put shape and sense to the ethics of managed care.

Ethics is a code of principles of conduct, guidelines for right and wrong. For medical practitioners, the Hippocratic Oath is a centuries' tested statement of ethics. But much has changed since those dreamy days on Kos. Recently, issues like living wills, DNR/DNI, and organ transplantation, which teeter along the edge between life and death, have filled most biomedical ethics prose. However, as noted in our portrait of the University of Minnesota Center for Biomedical Ethics (page 18), the themes are virtually limitless. Uni-

versity ethicists define biomedical ethics as a "mode of inquiry" that delves into values behind medicine. The anaplastic growth of managed care is providing fertile ground for the inquiring minds at the center.

Any good ethicist is like the Sphinx, asking tough riddles and supplying only some answers. Our profile of Allina's John Kleinman, M.D., (page 6) and our cover story on ethics and managed care (page 10), provoke the following questions—and if my answers prove wrong, I hope the sentence will be lighter than the Sphinx's death penalty.

- What started this whole debate about managed care ethics? Money. With unlimited resources, medicine would still be lolling in the surfeit days of LBJ.

- Who decides how much is spent and how it is spent? That costly instrument, the physician's pen, is the focus of a tug-of-war between legislators, buyers, MCOs, and physicians themselves. Whatever the MCO structure, however, physicians will always write the orders.

- How will we guide physicians to make economically and ethically sound decisions? Economic withholds, bonuses, and capitation, as well as clinical measurements, like guidelines and outcomes, seem to be the current methods of choice for steering physician behavior.

- Should the diagnostic and treatment decisions doctors make be right for the individual patient or right for the population? There's no doubt which Hippocrates had in mind: "You will exercise your art solely for the cure of your patients." But, just as corporations don't pollute in a closet, physicians can't totally ignore the impact of their decisions outside the exam room. One patient's MRI may mean many fewer immunizations or well-baby visits.

Steve Miles, M.D., of the Center for Biomedical Ethics, speaks of developing a "canon" of medical ethics, a modern medical Ten Commandments. He contends that we have reached a consensus about a number of issues, such as stopping life support at a patient's request. Whether we can develop a canon for using medical resources in a managed care environment hinges on agreeing about concrete principles of ethical MCOs (see page 8) and also about will-o'-the-wisp phrases like "strong physician-patient relationship" and "medically appropriate."

The *fatuus* of *ignis fatuus* and the *moron* of oxymoron come from roots meaning foolish. The last thing we want our code of conduct to be is foolish. Neither do we want it to be undefinable. Only honest, hard questions about how we run our professional lives will lead us to humane rules by which to live. The answers won't be written in stone, but they should be easier to grasp than moonbeams. MM

Protecting Patients & Profits

As a physician and an Allina vice president, John Kleinman, M.D., is watching out for patients' interests and Allina's bottom line.

When John Kleinman, M.D., began his internal medicine practice 17 years ago, a small, relatively new HMO at St. Paul-Ramsey Medical Center was doing poorly—and Kleinman wanted to know why. Little did he know where his curiosity would lead. “Managed care became an area of interest that just kept burgeoning for me,” says Kleinman, who is now vice president of clinical services for Allina Health System. “For some years, I tried to divide my time between my practice and administrative work, but a few years ago, I realized I had to make a choice between the two. I chose this direction. I have a great passion for clinical quality improvement, and now I have a way to pursue it.”

The results of Kleinman's work stand to have an enormous impact on Minnesota health care consumers. Today, Allina's 20,000 employees and 6,000-plus affiliated physicians serve 950,000 enrollees in Medica and in Allina's SelectCare PPO—a 23 percent market share.

In his position with Allina, Kleinman finds himself in the middle of what is perhaps *the* conundrum for managed care, if not for our country's entire health care system: trying to do what's best for the patient while controlling the bottom line.

How much control do managed care plans exert over physician decision-making in Minnesota? “Probably not a lot,” says Kleinman, who prefers to frame the issue differently. “I don't believe that doing what is best for the patient is always clearly understood or defined. Frankly, much of what is done in medicine is *not* evidence-based, and that's where so many questions arise. When is a given screening test useful and

effective? Which antibiotics work best for the lowest cost? Too often, we don't know the answers to such questions.”

Establishing Practice Guidelines

To help improve care, the group Kleinman leads is closely examining the latest scientific literature. “What I and many others are trying to do at Allina is establish clear, evidence-based, best-of-practice guidelines for disease groups, populations, and diagnoses,” he says.

Kleinman and his team are sure to involve the people who provide care. “Physician involvement at Allina extends into best-of-practice development, medical policy councils, patient satisfaction analysis, customer service, and clinical outcomes,” says Kleinman. Allina has made changes that increase provider participation in program development and decision-making, establish fair risk-sharing relationships, and improve administrative practices. The Allina Physician Council, consisting of 20 physicians, works with Allina's top executives to address strategic issues, and half of Allina's board members are physicians.

According to Kleinman, solid data for developing best-of-practice guidelines have been scarce and poorly disseminated—until now. “We're finally getting what we need to develop good practice parameters,” says Kleinman. “The U.S. Preventive Services Task Force, for example, recently came out with over 200 efficacy guidelines for preventive health measures and testing. This report is based on very good science, and it's exactly what we need to make medicine more evidence-based.”

The next step, he says, is to look at patterns of care

By Joseph Moriarity

and compare them with best-of-practice guidelines. "Another of my team's key roles at Allina is to show providers how they practice. We contractually obligate our providers to participate in practice improvement, and we send them cost performance and patient satisfaction information so they can compare themselves with others in their specialty. And we've begun adding best-of-practice information, too. We find that if you give providers this kind of information, they do improve their practice."

Promoting High Ethical Standards

Kleinman believes the greatest abuses in managed care come with capitation, particularly when health plans are for-profit. "Such plans take a very large percentage of premium as profit to distribute back to shareholders," he says. "What's more, this fact is often not disclosed to customers—and that, in my opinion, is unethical."

Kleinman regularly refers to ethical concerns when talking about managed care, and he proudly points out that in June 1995, the Allina Foundation co-sponsored the first national medical-legal conference on managed care and ethics with the American Society of Law, Medicine and Ethics. "There have been abuses in managed care," he says. "That's clear. But we can prevent them." In fact, the Allina Foundation helped define the characteristics of an ethical managed care organization (see sidebar, page 8). Allina has incorporated these principles into its operations.

"While excessive profit-taking is a problem in some organizations, at Allina, we believe that after coverage of risk, profits should be used to increase access and improve quality and service,"

says Kleinman. In Minnesota, managed care organizations must be nonprofit, and their net profits are limited by statute.

"We're allowed one cent per dollar of revenue," explains Kleinman. "The rest has to be plowed back into patient care and/or used to reduce premiums. This is not the case for indemnity insurers, however, which can be—and are—for-profit, with no constraints on net profit."

Managed care organizations in Minnesota must have a risk-bearing mechanism such as capitation or, in lieu of that, a 15 percent provider contingency reserve. Allina, which Kleinman describes as a "managed fee-for-service organization with very little capitation," bases physician bonuses on yearly provider performance reviews—which include peer resource utilization comparisons and patient satisfaction results. Kleinman would prefer to base performance bonuses only minimally on resource consumption per se, with more weight placed on quality of practice, patient satisfaction, access to care, and appropriate pharmaceutical use. "That's the ideal, and we're getting there," he says. "I see improvement in cost as a *byproduct* of quality improvement—which best-of-

practice guidelines will ensure. Much can be done to develop system and process improvements that, in turn, reduce costs. The opportunities are there, and they're all linked with clinical practice improvement."

Expanding Allina's Network

When Allina was first formed in 1994 by the merger of the HealthSpan hospital chain and the Medica health maintenance organization, says Kleinman, "we thought each part of the organization

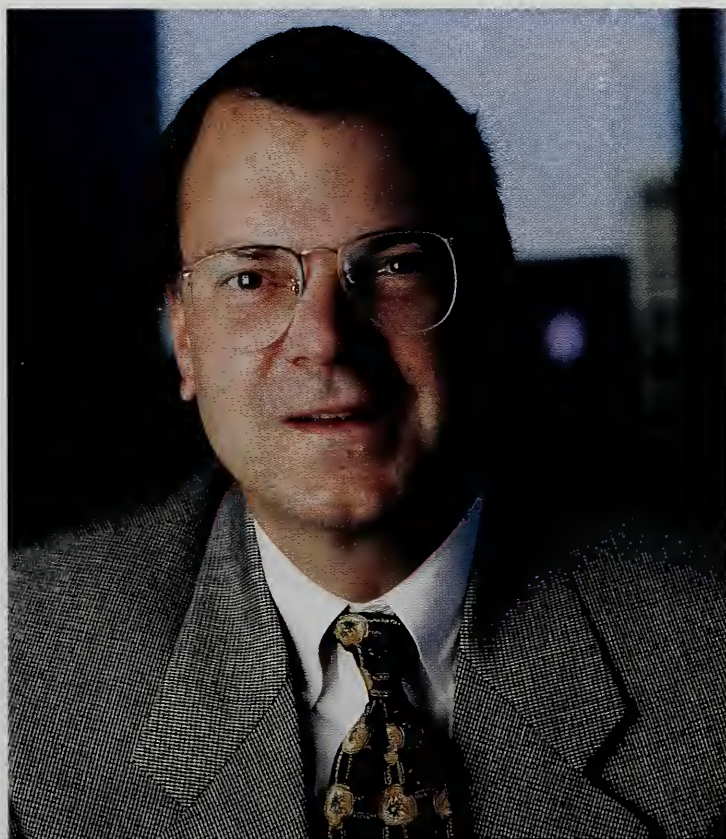


Photo of John Kleinman by Bruce Baird

CHARACTERISTICS OF ETHICAL MANAGED CARE ORGANIZATIONS

should continue to operate independently. Now, however, we are moving to a more interdependent organization. While the Allina Medical Group is a fully integrated practice, the majority—about 85 percent—of the network is independent.”

In the not-too-distant future, Kleinman thinks most providers will be aligned, but not solely with one group. “Providers will continue to sign and work with multiple organizations,” he says. “The networks need to be diverse because that’s what consumers want. Medica’s largest and best-selling products are its open-access choice options. Members do not want to be restricted when choosing their primary physician. People want their doctor in the network, and that creates pressure to be broadly connected.”

Further expanding Allina’s network of providers is one of the organization’s broad goals for the coming year or two. “Other goals,” says Kleinman, “include a strong focus on clinical quality improvement, giving providers better information about their practice to foster improvement, and being an even more accountable organization to both members and purchasers. And last, but certainly not least, Allina, along with all other managed care providers, has the goal—as required by state statute—to limit health care cost increases to the consumer price index by 1998.”

Setting Goals in a Rapidly Changing Marketplace

The market’s instability makes setting goals difficult, says Kleinman. “It’s simply hard for us to do good long-range planning because the market can change

Ethical managed care organizations:

1. Support strong physician-patient relationships.
2. Support and promote quality improvement through evidence-based, best-of-practice guidelines.
3. Make reimbursement strategies public and base reimbursement on quality, not quantity.
4. Involve the people who care for patients—physicians and other providers—in the development of medical policy and quality practice.
5. Support the right to medically appropriate health care resources.
6. Educate members on the terms and limits of coverage—and are prepared to disclose reimbursement methods.
7. Use profits after covering risk to increase access, quality, and service.
8. Serve *all* payer groups—including Medicaid and Medicare.
9. Are accountable to such national measures and standards on quality and outcomes as the Health Employee Data and Information Set (HEDIS), and to national credentialing bodies, such as the National Council on Quality Assurance (NCQA).

so quickly. As I tell people, leave town for a week, and the whole landscape can be nearly unrecognizable when you return. No one can accurately predict what it will look like in two years.”

Given the new initiative of the Buyers Health Care Action Group (BHCAG), Kleinman’s comment is not mere hyperbole. After years of work to bring provider groups and organizations together in more integrated systems, BHCAG seems to have dramatically changed course. According to BHCAG Executive Director Steve Wetzell, BHCAG is altering its buying model “to create a market more directly driven by consumers and provider responses to consumer needs.” The new model introduces three key changes: direct contracting with multiple care systems, better consumer information, and varied premiums based on care systems’ claim targets.

“Their goal, as I understand it, is to increase competition by breaking up the systems,” says Kleinman. “In HealthPartners, for example, the provider groups are Park Nicollet Clinic, Group Health, and independent contractors. Under BHCAG’s proposal, each must now bid separately for contracts.” The Allina Medical Group is currently the second largest provider to BHCAG, “so of course, we

will participate,” he says.

Is the BHCAG model the answer? Kleinman doesn’t know. “It needs to be tested in the marketplace along with the other models. We’ll just have to wait and see. And in the meantime, Allina will continue pursuing quality improvement and cost-containment efforts within the organization.”

MM

Joseph Moriarity is a free-lance writer living in Marine on St. Croix, Minnesota.



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Managed Care Ethics

*While health plans
in some states use
gag clauses in
physician contracts,
Minnesota seems to
have steered clear of
this unethical
practice—but that
doesn't mean ethics
isn't an issue here.*

MINNESOTA seems immune to managed care horror stories that infect other parts of the country. No gag clause-itis. No \$89 million settlements against HMOs for patients denied care. And no front-page headlines about Minnesota physicians motivated by financial



A Delicate Balance

by Howard Bell

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incentives to skimp on care. AMA attorney Carol O'Brien says she's received numerous complaints about gag clauses and other ethical felonies from physicians in just about every state but Minnesota. Most complaints come from California and the Northeast, where Darwinian managed care markets run amok.

Gag clauses limit physicians' free speech and make doctors appear unsympathetic to their patients' plights. Under typical gag clauses, physicians can't discuss treatment options before receiving authorization, and they can't discuss treatment options not stocked on the plan's shelf. Some physicians can't even initiate appeals on behalf of patients. There's no referring patients to physicians outside the plan's network, even if the physician believes it is in the patient's best interest. Physicians terminated—"deselected" in managed care-ese—are prohibited from discussing their terminations with patients or anyone else. And don't even think about bad-mouthing the plan to patients or colleagues. That's grounds for deselection.

If such clauses are used in Minnesota, no one's fessing up. Numerous physicians, attorneys, and managed care administrators interviewed for this story say they have not seen gag clauses used here. Michael Scandrett, director of Minnesota's Council of HMOs, says none of Minnesota's nine HMOs uses them, and anyone who did would be foolish. "Physicians have to be free to discuss patient care issues," he says.

Congress may soon agree. Pending federal anti-gag rule legislation (H.R. 2976) would penalize plans for using gag clauses that interfere with physician-patient communication. The bill also would protect managed care organizations (MCOs) against "malicious, defamatory remarks made by physicians about the MCO." Since 1995, at least seven states have passed their own anti-gag clause bills. (Minnesota has had its own statute on the books for years.) Meanwhile, the AMA has issued guidelines for ethical managed care condemning gag clauses and invites all physicians

to submit their contracts for free analysis to determine if they obstruct physician-patient communication.

Minnesota Nice

Does Minnesota simply know how to do managed care right? Many physicians say yes. "If you want to look for bad apples in Minnesota, you're going to have to import them," says Allina Vice President of Clinical Services John Kleinman, M.D.

Overall, Minnesota managed care gets good marks from Mayo anesthesiologist and Minnesota Medical Association President Michael Murray, M.D., who says, "Gag clauses are not used in Minnesota, partly because reimbursement rates have not been ratcheted down as in other states."

For-profit HMOs are responsible for much of the ethical havoc in other states, according to Steve Miles, M.D., of the University of Minnesota Center for Biomedical Ethics. Minnesota does not allow for-profits. Here, premium dollars are put back into health care, not siphoned off and given to stockholders.

Last year, Minnesota's HMOs used 98 percent of every premium dollar to provide patient care, according to Scandrett. For-profits pay out 25 cents of every dollar to stakeholders, while administrative costs among Minnesota HMOs average 9 percent, lower than industry average, he says.

Marvin Segal, M.D., has practiced clinical and administrative medicine for more than 20 years and with five different Twin Cities health care groups. "I've lived through the whole thing and believe managed care works," he says. For starters, Minnesota physicians have actively shaped managed care since its 1980s inception. "Doctors knew if they didn't have significant say in how it was structured, Minnesota would become an undesirable place to practice."

Early physician involvement starting at the top, says Segal, is the most effective deterrent to managed care running roughshod over doctors. State HMO legislation requires that physicians be strongly represented on health plan governing boards. Physicians

"Minnesota
physicians take
their Hippocratic
Oath seriously
no matter who's
paying the bill."

—MARVIN SEGAL, M.D.

control quality assurance, utilization review, and credentialing committees, and they oversee patient care councils that write utilization rules. MCOs spell out step-by-step appeals processes so physicians can advocate for patients denied authorization.

Several physicians volunteered a more subjective reason for Minnesota's managed care success, best summarized by Segal. "Minnesota nice," he says. "That's the simple answer, but I believe it's not far off the mark. Minnesota physicians, in general, take their Hippocratic Oath seriously no matter who's paying the bill."

Money Talks—Docs Walk

When it comes to who's paying the bill and how much they're paying, many physicians do not agree with Segal's assessment that Minnesota MCOs don't wield excessive control over doctors. Salary bonuses and withholds, especially under capitation, say some physicians, are unethical because they pressure physicians to limit care and walk the line between what's best for the patient and what's best for the plan. Managed care has built-in incentives to not refer, not order tests, or delay treatment.

Salary withholds of 10 percent to 20 percent are typical in Minnesota, according to Michael LaFond, a health law attorney with Oppenheimer, Wolff & Donnelly in Minneapolis. Withholds, he says, are a common practice designed so physicians in group practice share risk for providing care under various non-fee-for-service arrangements. "During the HMO price wars of the '80s, doctors complained because they weren't getting their withholds. Now they are, in part because they've changed their practice patterns." LaFond says smaller group practices that network with others to form larger networks without merging are required to either use capitation or share risk of at least 20 percent.

MCOs share risk, through capitation or fee withholds, to contain costs and to comply with laws, says Allina's Kleinman, "I don't think many physicians realize we are legally required to withhold."

Risk sharing may translate into a lower salary in closed panel MCOs. Risk and reward systems for nonsalaried physicians are more variable. Medica, for example, withholds 15 percent for all services rendered under fee-for-service products, except for Medicaid. Allina places withholds in an interest-bearing account. At year end, if the physicians' utilization and patient satisfaction profiles are consistent with their colleagues' and the plan has performed well financially, they get it back.

Steven Richards, M.D., senior vice president of health care management at Blue Plus, prefers not to

give exact percentages, but says Blue Plus' withholds are "comparable" to Allina's. Blue Plus factors in case load difficulty when calculating withhold returns, says Richards, and it shares risk burdens when a partner clinic has an exceptionally expensive year.

Allina bases withholds on how a physician's utilization and patient satisfaction compare with the rest of the group in that specialty. "Only 2 to 4 percent of Allina physicians do not get their entire withhold back," says Kleinman, who admits that most physicians are unhappy about withholds, but says Allina is searching for ways to ease the cash flow pain. Currently, its physicians receive statistical documentation and can appeal a withhold decision.

Jim Rusin, M.D., medical director and family practitioner with East Main Physicians in Anoka, complains that physicians sometimes don't know until spring of the following year how much of last year's withhold they get back. "It's hard to budget not knowing how much money you've made," he says. "I can't withhold wages from my staff. Why can't [the health plans] give it back quarterly or semi-annually?"

Deputy medical director at St. Paul-Ramsey, James Hart, M.D., also is leery of withholds. He and his former partners in a Stillwater clinic did 50 percent of their business under capitation but refused to participate in withholds. He views them as a discounted fee-for-service on top of already discounted fees for service. "Many years you don't get paid back fully," he says. "When you add a 20 percent withhold onto 50 to 60 percent overhead typical in primary care, there's not much left." Hart says decisions to give back withholds are often arbitrary and based on too little data.

Conversely, Minneapolis neurosurgeon Andrew J.K. Smith, M.D., argues that withholds don't have much effect on physicians. "They're primarily a way for health plans to satisfy legislative requirements for reserves and as a pool to redistribute revenue from specialists to primary care," he says.

Smith believes year-end bonuses are more ethically troublesome because they encourage underutilization more than do withholds. "Bonuses clearly create conflict between patients and physicians," he says. "Physicians won't order a test or make a referral. It's happening every day." He argues that bonuses should be based on productivity, quality of outcomes, or patient satisfaction, not on savings to the plan for not ordering tests or referring (see related editorial, page 24).

Twenty-five percent of Allina's withhold and bonus pool formulas are based on patient satisfaction. Bonuses come from a discretionary provider performance pool, available to all providers who are subject

to withhold and at financial risk. The pool gets distributed based partly on an individual's utilization and patient satisfaction scores. Blue Plus calls bonuses "care incentives" and awards them to clinics with exceptional immunization rates and patient satisfaction.

Quality—Still Job One?

Financial incentives change how physicians practice medicine, but do they affect outcomes? Miles has reviewed 20 studies on managed care's effect on quality. Taken as a group, he says, the studies show no loss of quality under managed care. "There's no difference in hard indicators like death. Managed care uses hospitals and ICUs less, but it uses preventive services more," says Miles, who also found that managed care outcomes were better than fee-for-service for "soft indicators" like blood pressure and diabetes management, birthweight, and detection of cancer.

Withholds, capitation, and bonuses each have their own potential downfalls when it comes to quality care. When withholds put pressure on cash flow, primary care physicians might be tempted to increase the volume of care to raise revenue. Meanwhile, the temptation to underutilize is greatest with capitation and bonuses, which lead doctors to think twice about referring.

The problem is that no one has come up with a way to pay physicians that does not have inherent conflicts and that is also acceptable to most physicians. Until outcomes measurement is sophisticated enough to serve as the primary basis for financial incentives, the only reasonable approach is to limit the extent to which a physician's ordering of services can affect income.

Kleinman says most Medica products have no built-in incentives to limit referrals. He agrees that the risk of undertreatment is greater under capitation, but Allina does not do as much capitation as it used to. Besides, the notion that capitation causes undertreatment is theoretical. "It's been studied," he says, "but never conclusively proven true."

Whether undertreatment is a problem in Minne-

sota or not, primary care doctors are increasingly susceptible to liability for undertreatment because of nonreferral, says the AMA's O'Brien. Take, for example, the California woman with pelvic pain and rectal bleeding who was denied a referral until her husband

demanding it. By then, she had advanced colon cancer and died shortly thereafter. A jury awarded her family \$3 million. Another California jury awarded a staggering \$89 million to the family of a woman who died of breast cancer after being denied an autologous bone marrow transplant. "Juries do not look favorably at capitated arrangements and bonus pools," says O'Brien.

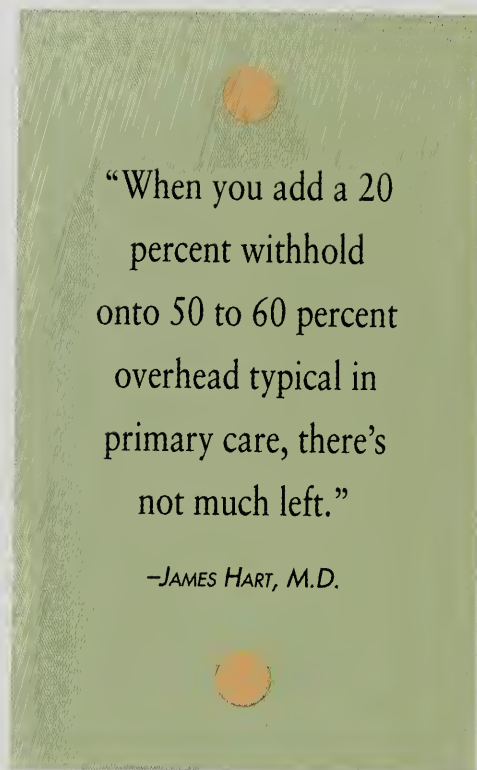
Meanwhile, federal law protects self-insured employers, which account for two-thirds of Minnesota's employer health plans, against liability for negligent utilization. They're also exempt from state treatment mandates. Physicians providing care to patients in those plans are left to hang in the litigious breeze.

Psychiatry is one area of medicine that has expressed bitter complaints against managed care. Psychiatrists accuse

for-profit behavioral health clinics, in particular, of jeopardizing quality of care by underutilizing psychotherapy and hospital stays and reducing psychiatrists to medication dispensers with little decision-making power. "When it comes to psychiatry, managed care worships at the altar of economics and has created an ethical vacuum," says Charles McCafferty, M.D., an independent psychiatrist in St. Paul (see *Minnesota Medicine*, January 1996).

Segal admits managed care payment formulas subtly reward nonreferral in many areas, but says steps are in place to ensure that underutilization does not occur. Besides, he says, most physicians know their limits. "It's inconceivable to me that physicians would stretch their expertise, or practice a different kind of medicine, depending on what plan covers a patient. I see it as a plus. Managed care makes the most of a well-trained primary care doctor's considerable skills."

Besides, Segal says, quality among MCOs does





not vary as much as the public thinks. For one thing, most physicians belong to more than one plan, so there's great overlap in who's providing care in various plans. Objective performance measurements are used more, too. Some health plans, like Medica, have obtained National Committee on Quality Assurance accreditation based on 50 standards for utilization, quality assurance, and medical records. Blue Cross and Blue Shield of Minnesota and Group Health are well on their way to achieving accreditation.

MCOs are as interested in quality as anyone else, says Scandrett. "HMOs are doing much more to improve quality than fee-for-service ever did. We're sharing outcomes information and determining the best practice approaches. Under fee-for-service, there was little collaboration or elimination of ineffective treatment variations."

Even utilization review has become more quality focused. Once used mostly to spot overuse, MCOs now use UR to identify new ways to improve care. Furthermore, say managed care advocates, corporations are as interested in getting good care for their employees as they are in containing costs. If MCOs don't deliver on quality, employers will go elsewhere. As Richard Scott, CEO for Columbia/HCA Healthcare Corporation said in a recent *Business Week* article, "The future belongs to whoever best measures quality of care and then markets it the best."

Keeping the Balance

Tragic anecdotes make news, but they do not represent Minnesota managed care—so far. And perhaps

the legal system that awards giant liability settlements against MCOs has not caught up with the realities of rationed medicine, where resources are finite, especially for high-stakes, high-cost procedures with an uncertain likelihood for success.

Herein lies the ethical crux. As a society, we still view medicine from the individual's vantage point. What the individual patient wants, the individual patient should get. Miles says that traditional approach is unethical. He poses the question: To whom is the plan beholden? "Someone who needs a heart transplant is served when he gets one, but that money could instead have been spent on ways to lower risk for cardiac problems. It's socially destructive for medicine to make utilization decisions solely in the individual's interest."

For now at least, managed care is our best shot at containing costs and balancing individual needs with needs of other plan members, says Smith. "As long as you maintain a balance, it's possible to practice good ethical medicine under managed care."

Nonetheless, such an approach conflicts with a physician's traditional role as patient advocate. Suddenly, physicians are forced to be guardians of society's limited resources. Budgets determine the amount of care available, and physicians must now weigh the legitimacy of an individual's medical need against the MCO's need to serve all patients and control costs.

continued

Different Issue In Disguise?

Gripes about payment schemes and authorization hassles aside, outcomes research suggests it's premature to condemn managed care. So why so much grumbling? St. Paul-Ramsey's Hart suggests what really irks physicians is not the ethics or the money, but the loss of control. "It's an interesting and delicate subject," he says. "Loss of control is often misrepresented as a quality or ethical issue. All but the youngest physicians practicing today felt they'd be more independent. Instead, many find themselves just another employee in a big corporation." Hart believes physicians in general are unhappy. "I'm concerned about middle-aged and older physicians—about their mental health.

"Physicians ask themselves if they can be fulfilled as corporate worker bees," says Hart. "As a group, they have been reluctant to admit it could have been different if the profession had organized and taken financial risks. Risk-takers don't go to medical school, which is probably a good thing for patients, but people who take the financial risks get the control."

St. Paul psychiatrist McCafferty waxes philosophic and quotes Yeats: "The falcon cannot hear the falconer. The best lack all conviction. The worst are filled with passionate intensity. Will the center hold?" **MM**

Howard Bell is a free-lance writer living in Onalaska, Wisconsin.

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MODE OF INQUIRY

BY MIRIAM K. FELDMAN

At the University of Minnesota Center for Biomedical Ethics' 10th anniversary celebration last fall, Paul Quie, M.D., the center's first interim director, reflected on Jamie Fiske,

the young girl who made headlines when she received a liver transplant at the 'U.' He recalled how Fiske's father had used his clout to appeal, through the media, for a liver for his child. A liver was found and medical history was made in 1982.

The story had a happy ending, but as Quie noted, the case served as a flashpoint, bringing attention to bioethical concerns. The medical community was "uneasy" with the way donors could be solicited, he said. Four years later, the Center for Biomedical Ethics was established to contemplate the kinds of issues raised by the Fiske case—issues that arise when social and medical questions converge in an increasingly high-tech world.

The mood was anything but uneasy, however, when the top-ranked Center for Biomedical Ethics celebrated a successful 10 years, during which it has helped inform the debate on everything from specific,

cutting-edge advances like the use of human fetal tissue, to broader issues like the values that drive health care reform.

The center's success has been attributed to a number of factors, including the unflagging support of both the university and the community, the quality of its faculty, and the early leadership of Arthur Caplan, Ph.D., who has since moved to the University of Pennsylvania to direct its Center for Bioethics. The University of Minnesota center has grown up in a time when bioethics has pondered everything from organ donation to Baby M and surrogate mothers. Now, moving into its second decade, the center will be led by a new director, Jeffrey Kahn, Ph.D., M.P.H. (see sidebar, page 20), who hopes to take the center beyond bedside issues to the more global needs of the community at large.

A TOPFLIGHT ORGANIZATION

If success can be quantified, the Center for Biomedical Ethics has more than earned its reputation as a topflight organization. According to its 1994 annual report, the center's faculty published more than 60 articles that year in professional journals, handled nearly 500 inquiries from local and national media organizations, taught some three dozen university courses, and led conferences on a number of ethical issues, from individual responsibility for health to the ethical issues of adoption.

Center faculty advise graduate students, design curricula and lectures for the university's medical school, testify before federal and state legislative bodies, participate in continuing education courses around the country, present papers at national and international conferences, and serve as advisers or board members to more than 70 organizations, including the American Medical Association, the Minnesota Medical Association, the American College of Physicians, and the state of Minnesota.

"We get called every day," says Steve Miles, M.D., the center's director of medical ethics education and associate professor in the university's Department of Medicine. "One day, it may be a legislator calling, that afternoon, a disability rights group asking for information." There are requests to attend conferences and conduct seminars.

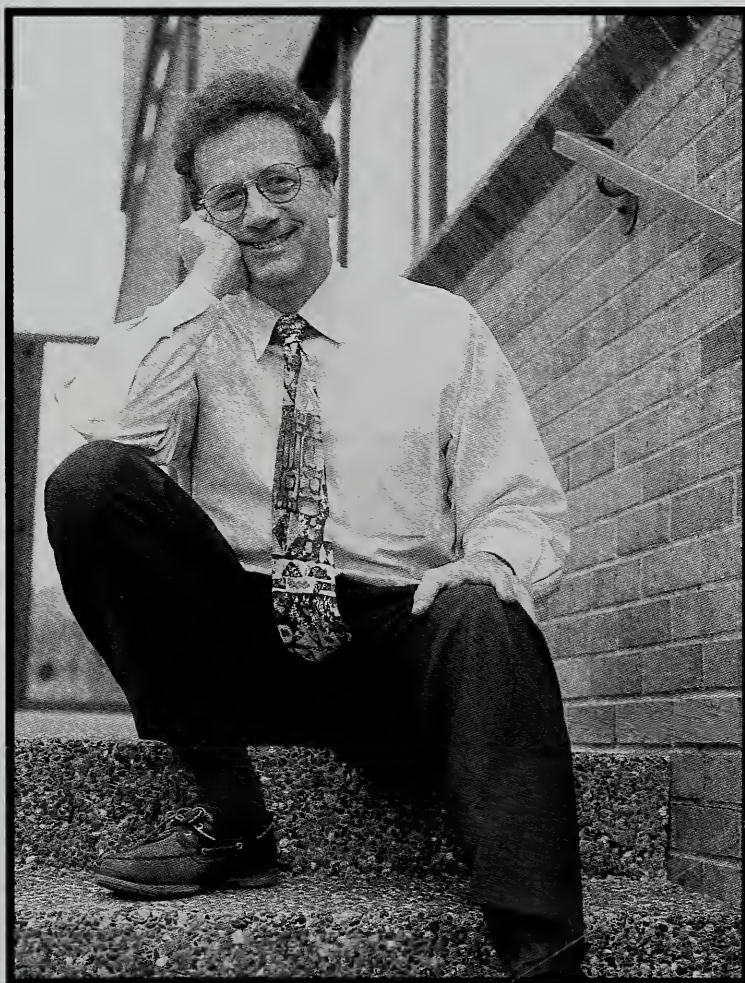
There are calls to speak to groups like the Minnesota Senior Federation, or to submit papers to the *New England Journal of Medicine*.

ROLE OF BIOETHICS

Despite this flurry of activity, bioethics is at a crossroads, according to Caplan, who spoke last October at the anniversary celebration, where he challenged the audience to consider what might happen to bio-

"Bioethics is at its best a mode of inquiry, rather than a fountain of sure answers."

—STEVE MILES, M.D.



MELISSA COOPERMAN

J E F F R E Y K A H N

NEW DIRECTOR WANTS TO HELP CENTER FIND ITS NICHE

The University of Minnesota Center for Biomedical Ethics moves into its second decade with a new director, who isn't afraid to follow in the footsteps of Arthur Caplan, the center's first director. Caplan, who left the center in 1994 to direct the University of Pennsylvania's Center for Bioethics, is widely recognized for his wit and media savvy, as well as his bioethics expertise.

"He left some pretty big shoes there," concedes Jeffrey Kahn, Ph.D., M.P.H., who arrives to take the helm in August. But, he adds, "I bring my own personality and my own way of doing things."

Kahn also brings a new vision to the center as it embarks on what many are calling its next 10 years. He discussed that vision and how it relates to the ever-evolving field of bioethics in a phone interview from his office at the Medical College of Wisconsin-Milwaukee, where he is assistant professor and director of the graduate program in bioethics, which he developed.

"I'm in the next generation," says 35-year-old Kahn, who speaks about being part of the next wave. "There's an evolution in the field, and I represent that."

Historically, bioethics has been concerned primarily with the physician-patient relationship, where the focus has been on high-profile, individual cases associated with big names, such as Karen Ann Quinlan. Now the field is progressing toward bigger-picture issues related to health and

social policy, and it is moving from being reactive to proactive, Kahn says. NIH funding of the Human Genome Project, for example, was the first time in the field of bioethics that money was appropriated for issues that haven't yet materialized. And work in the area of managed care ethics, much of which is being done at the University of Minnesota Center for Biomedical Ethics, may have an impact on health care delivery.

"It is important to talk about when is it OK to turn off life support," Kahn says, noting that many institutions are still looking at more traditional bioethics concerns. "I don't think you leave one issue behind for the other. But the focus is evolving."

Kahn's background combines philosophy with public health, making him well-suited to cutting-edge bioethics. He holds a doctorate in philosophy with a specialty in bioethics from Georgetown Uni-

versity, as well as a master's of public health degree from Johns Hopkins University. "There's a niche in the field that hasn't been fully taken advantage of, which is ethics and public health policy," says Kahn, who would like to see the center find a foothold in that niche.

Kahn recently spent 18 months serving as associate director for the White House Advisory Committee on Human Radiation Experiments. The committee's charge was to uncover what happened in



the past and to make recommendations for designing policy to prevent any future wrongdoing. His leadership of that 65-member committee was one of the credentials that made him an attractive candidate for the director's job, according to Dianne Bartels, the center's interim director. It demonstrated his ability to lead a group of people in an academic realm, as well as to deal politically with powerful people, she says.

Kahn describes his style more succinctly. In a word, it's collegial, he says. "I try to be very open and hear what everybody has to say, but I also know when to take responsibility."

One of his plans is to take responsibility for further developing the university's graduate minor in bioethics. "One of the things I will do is make that a larger presence," he says. He also would like to strengthen ties in the areas of law, medicine, public health, and philosophy. And he'd like to see the bioethics research done in any university department funneled through the center, making it a "cornerstone" for bioethics on campus.

Despite his plans for change, Kahn comes to the center with the understanding that it is, as he puts it, "one of the premier places in the country with some of the best scholars in the field." He sees his role not as a savior, but as a leader who can move the center along in a direction it's already headed. "It's not like the center needs someone to come in and inject new life into it. To the contrary. It's not that it needs to be picked up and taken to the next level. It's ready to do that," he says.

"But there's a time for vision," he adds. "There's a field that has to be mined that relates to this nexus between ethics and policy. That needs to be further pursued. I would like to be one of the people doing that."

—MKF

ethics when money gets tight. "Can bioethics face the challenge of explaining what it does?" Caplan asked.

The center's new director certainly can, yet he concedes that the business of bioethics might appear confusing to outsiders. "What do you call somebody who is a bioethicist? Are they an expert in anything in particular?" Kahn asks rhetorically. "If you have a problem with your kidneys, you go to a renal expert. They are legitimately an expert. They have information others don't. In ethics, everybody has an opinion."

Still, Kahn argues that bioethicists help advance discussion in ways that otherwise might not happen. "I can help you understand how to think through a problem and what the issues are," says Kahn, who has degrees in both philosophy and public health.

Bioethics can mean different things to different people, according to Miles. "Some people have agreed that medical ethics gives voice to lay perspectives against excessive professional control," he says. While others say it's a form of academic inquiry or a forum for the community. "Bioethics is at its best a mode of inquiry, rather than a fountain of sure answers. It's a way to approach problems, rather than a set of people who come down with the absolute truth."

Miles illustrates the bioethicist's unique approach with the example of 43 million uninsured people in our society, which typically is treated as a problem for political scientists or economists. "We've participated in framing that as an ethics question," he explains. "Rather than seeing 43 million uninsured simply as a social problem, let's think about it in terms of the values our society espouses and see if this problem looks any different in terms of the values we claim to uphold. When you do that, you transform the question."

Ronald Cranford, M.D., agrees that bioethicists put a different spin on questions by imposing a discussion of values, something doctors aren't necessarily trained to do. Doctors are pragmatic, utilitarian, and outcome-oriented; they tend to approach every problem as a medical decision, says Cranford, a neurologist and medical ethicist at Hennepin County Medical Center. Bioethicists approach problems that appear to be exclusively medical through the prism of many disciplines, including philosophy, law, and sociology.

"Just because a decision is made by a doctor doesn't make it exclusively a medical decision," asserts Cranford, who is chair of the MMA's Committee on Ethics and Medical-Legal Affairs. For example, determining whether a person is in a vegetative state is strictly a medical decision because it is based on facts, he says. On the other hand, decisions about how to

treat that person are value-based, evoking questions such as, "When does personhood begin and end?"—questions ethicists can help us understand.

There are many unresolved questions in the field of bioethics. "The field has gotten so large that nobody can do serious work on the entire domain," says Miles, who has a national reputation for his work related to the ethics of managed care. The biggest, and possibly most fascinating, question raised by managed care, according to Miles, is whether physicians are accountable to individuals or to the entire popu-

lation of plan members. In a fee-for-service setting, the physician has an obligation to the patient in need at the moment. "But in managed care, I have the same obligation to you as to the person who sits in front of me tomorrow," he says.

"We're saying we're going to have these organizations responsible for defined populations on a defined budget, with a defined set of benefits. Once you say that, you change the relationship between doctors and patients," Miles says. "The question of how do people understand these relationships raises a host of ethical questions."

If bioethics means transforming the questions, it also means providing information to answer those questions. Kathy Faber-Langendoen, M.D., has been doing just that for seven years in a study of how patients die in high-tech settings. As part of the center's humane care of the dying patient project, she has looked at the management of ventilators to help understand how medical technology fits into care of the dying. Her study illustrates how physicians make and implement decisions to forgo life-sustaining treatment and looks at whether health care workers try to comfort the family or the patient.

"As those results [of the study] come out, we'll have the first good data set on what is important to families. When that is analyzed and published, it will provide a rich resource to physicians," says Faber-Langendoen, an assistant professor of medicine in the university's Division of Medical Oncology. "I think the idea is not so much for bioethics to decide something, but we can inform the debate and inform clinical practice," she says.

Informing the debate, rather than coming up with ready-made answers, is a hallmark of bioethics. Yet there does exist, according to Miles, a canon of bioethics; certain issues have been resolved and form a kind of body of law that governs our actions. Stopping life support at the patient's request is one issue that has been resolved. Forbidding experimentation on human subjects without

"The idea is not so much for bioethics to decide something, but we can inform the debate and inform clinical practice."

—KATHY FABER-LANGENDOEN, M.D.



MELISSA COOPERMAN

their consent is another.

But asking questions is as important as providing answers, according to Mila Aroskar, R.N., Ed.D., F.A.A.N. Like Kahn, she believes the Center for Biomedical Ethics helps us grapple with problems in a way that otherwise we would not. "It isn't that people don't discuss these issues, but I think these things aren't specially identified as ethical issues," says Aroskar, associate professor in the School of Public Health and the center's director of graduate studies. "My concern would be, if you don't have a center, some of these issues aren't identified as ethical. So some of those dialogues don't happen or people don't recognize them for what they are."

UNFLAGGING SUPPORT

Of course, medical ethics was a discipline before the Center for Biomedical Ethics was established. Aroskar, for example, did the first survey of ethics teaching in nursing curricula in the '70s, when ethics was also being studied by other disciplines at the university, including public health, philosophy, and dentistry. But it wasn't until students and faculty pushed for a place to house all these far-flung disciplines that the Center for Biomedical Ethics was born. Nobody needed much prodding, as Aroskar recalls. People were ready for it; the time was right.

University commitment to the center remains strong, despite the concerns raised by Caplan that bioethics might be perceived as expendable when money gets tight, says Dianne Bartels, R.N., M.A., who was interim director before Caplan started and has resumed that role until Kahn arrives in August. "Since the university's initial commitment to the center in 1985, we have had unwavering support for the



MELISSA COOPERMAN

"The center exists because of the open, progressive community in which we work."

—DIANNE BARTELS, R.N., M.A.

role of bioethics in the Academic Health Center," she says. Bartels, who teaches genetic counseling, believes that the university could have used Caplan's departure to withdraw its support and decide to spend its money elsewhere, but instead it helped the center launch a national search for a new director.

The university's strong support no doubt has something to do with the way the community has embraced it. "I've heard Art [Caplan] say one of the reasons he came here is [because] it's so unusual to find people who make public policy who are interested in having this kind of resource available," Bartels says. As she sees it, "The community is probably more educated than a lot of communities in the ethics of health care because of the center, but the center exists because of the open, progressive community in which we [work]." She says legislators and members of various boards and commissions look to the center as a resource for examining the ethical parameters of the issues they're facing.

That kind of interest is heartening to the center's new director, who believes bioethicists can and should play a role in policymaking. "It doesn't make any sense for us to be philosophers trying to parse questions," Kahn says. "It's interesting. But in terms of how we improve the way we live, how we practice or provide services, or make policy at a high level, there's a role for people like us."

MM

Miriam Feldman is a free-lance writer in Minneapolis and a frequent contributor to Minnesota Medicine.

Avoiding the Ethical Pitfalls of Managed Care

Managed care organizations can and should enhance patient care while fairly and cost-effectively distributing their limited resources.

Andrew J.K. Smith, M.D., Ph.D.

Ethics in managed care is not, as some critics have charged, an oxymoron. While managed care may create ethical dilemmas for physicians, it also has the potential to enhance and improve patient care. In Minnesota, where managed care is well-established, people have benefited from improved prenatal care, higher immunization rates, and lower health care premiums. The challenge is to understand and avoid the ethical pitfalls.

RESOURCE ALLOCATION

Ethical dilemmas arise when managed care systems create conflicts of interest for physicians. Traditionally, physicians have put individual patients' welfare above all else. Managed care systems, however, are responsible for an entire group of enrollees. These systems expect physicians to consider not only individual patients' needs, but also to weigh these needs against the need to care for all patients enrolled in the plan. Thus, a physician may be torn between loyalty to the individual patient and loyalty to the group as a whole.

This dilemma is inescapable in an era of modern technology and rising health care costs. Health care resources are finite; it is impossible to provide every procedure that might possibly benefit every patient and still manage to care for everyone. Thus, we must find a way to distribute health care resources equitably. There are several dif-

ferent theories of distributive justice.

THE UTILITARIAN THEORY

In the utilitarian theory, the welfare of the group takes precedence over the welfare of the individual. Utilitarians would restrict access to expensive and unproved medical technologies until they have been shown to be cost-effective, so money is preserved to care for others.

THE LIBERTARIAN THEORY

The libertarian theory would base access to benefits on patients' ability to pay for them. Proponents of this theory would limit the government's role to setting rules that establish a fair marketplace and would let people use whatever health care resources they could afford. Fee-for-service medicine is consistent with a libertarian viewpoint.

THE EGALITARIAN THEORY

The egalitarian theory is based on the idea that all people are created equal and deserve to share benefits as equally as possible. There are two versions of egalitarianism. Proponents of the first believe that after basic benefits are distributed, the division of resources should be based on individual initiative, effort, or merit. The idea of a standard medical benefits set with an option to purchase additional benefits is an egalitarian concept. Proponents of the second type of egalitarianism believe that resources should be given to those with the greatest need so that each individual

will have equal opportunities. The Mayo Clinic's attempt to save a 13 oz. newborn infant last year is an example.

THE REALITY

In practice, most managed care companies use a mixture of these theories. For instance, a managed care plan may offer a basic medical benefits set, which is an egalitarian concept. But the benefits set might exclude an unproved technique, such as autologous bone marrow transplantation, which would be a utilitarian approach. In addition, the plan may offer a point-of-service option that allows enrollees to pay more to see the physician of their choice, rather than be restricted to members of the plan network—a libertarian approach.

Whether the approach is egalitarian, utilitarian, or libertarian, health care systems can no longer afford to provide all care to all people, or to spend money on medical procedures that offer little chance of success. The latest statistics show that 30 million Americans are covered by prepaid managed care insurance, and the number is growing. Increasingly, there is incentive to avoid expensive care, especially if the procedure seems futile or if there is a less expensive alternative. The goal is to find ways to provide the best care at the lowest cost.

ASSESSING COST-EFFECTIVENESS

The Medical Alley Cost-Effective-

ness Task Force, which I chaired, released a report last year that will make it easier to assess cost-effectiveness.^{1*} The task force included representatives of a cross section of Minnesota's health care industry. The goal was to establish standard guidelines for judging the quality of a cost-effectiveness study, comparing and contrasting different technologies, and evaluating various studies of the same technology.

The Medical Alley report measures the "value" of a technology or procedure based on its ability to improve outcomes and patient satisfaction or to hold down costs, or both. It assumes that medical decisions should not merely be driven by cost, but should balance benefits and costs. In developing this report, the task force used information already available but known mainly in academic circles and made it practical, simple, and easy to use.

The Medical Alley report may help managed care physicians avoid ethical dilemmas. The guidelines will make it easier for physicians and health plans to judge the accuracy and validity of various cost-effectiveness studies and to make balanced decisions about health care treatments, technologies, and procedures.

FINANCIAL INCENTIVES

One ethical pitfall for physicians may arise when managed care plans use financial incentives that create a conflict of interest between physicians and patients. To control costs, some managed care plans encourage physicians to limit diagnostic tests, referrals to specialists, hospital care, or services by offering bonuses based on the amount of money spent on patient care or by withholding a portion of the physicians' reimbursement until the end of the year to cover possible shortfalls. These practices may put physicians' financial self-interests at odds with patients' welfare.

Capitation arrangements also create incentives to limit care. Under capitation, physicians are paid a fixed

amount for treating a particular group of patients. The fewer tests they order and the fewer patient services they provide, the higher the physicians' profits.

Financial incentives also are inherent in traditional fee-for-service medicine, but they operate differently. Under fee-for-service, the more patients physicians treat and the more procedures they perform, the higher their profit. The financial incentive is to order more tests or procedures. This practice is potentially unethical, but, generally, it does not pose as much risk to the patient as withholding care. When a physician orders a procedure, the patient has the option of seeking a second opinion, but if the procedure is never recommended, the patient has no way of knowing about it and doesn't recognize the possible need for a second opinion. Furthermore, "gag clauses," now appearing in many managed care contracts across the country (see cover story, page 10), prohibit physicians from disclosing to patients all possible treatment options.

Incentives and expectations of managed care are not inherently unethical, but they do raise concerns. Explicit or implicit policies may put pressure on physicians to cut corners. Ideally, managed care plans would design incentives that encourage a balance between physicians' obligation to provide care that will benefit patients and health plans' obligation not to squander its limited resources.

The American Medical Association Council on Ethical and Judicial Affairs published a report on the ethical issues raised by managed care financial incentives, which was summarized in the January 25, 1995, *Journal of the American Medical Association*.² The report includes guidelines to reduce the potential for financial conflicts of interest between physicians and patients (see page 30).

The AMA reaffirmed that despite any financial incentives, patient welfare must remain physicians' first concern. Physicians have an ethical responsibility to tell patients of all treatment alternatives regardless of cost and insurance coverage. Physicians also must disclose to patients

any financial incentives or contractual restrictions that may affect patient care. In some cases, a physician may be obligated to initiate an appeal on behalf of a patient who is denied insurance coverage for a procedure the physician considers necessary. The physician's first loyalty is to the patient, not to the health plan.

The AMA considers financial incentives permissible only if they promote cost-effective health care delivery, not the withholding of necessary care. The AMA report recommends the following means to ensure that managed care does not compromise patient care:

- Base financial incentives on the performance of a large group of physicians rather than individuals.
- Make payments on a yearly rather than monthly basis, allowing more opportunity to balance out a month in which some patients need unusually expensive care.
- Set reasonable limits on how much ordering tests or services can affect physicians' incomes.
- Develop health care allocation guidelines at the policy level. Physicians should not be asked to do bedside rationing.

PHYSICIAN-PATIENT RELATIONSHIP

Avoiding conflicts of interest or even the appearance of such conflicts is important to the physician-patient relationship, which is based almost entirely on trust. Knowing that physicians have taken an oath to put the patient's welfare first underlies this relationship and plays an important part in the healing process. Patients who trust their doctor to be their advocate are more likely to follow instructions, take their medicine, and, if necessary, put their life in their doctor's hands.

Managed care has the potential to support or undercut the physician-patient relationship. An article in the January 25, 1995, *JAMA* by Ezekiel Emanuel, M.D., and Nancy Neveloff Dubler³ defines the key components of the physician-patient relationship as the six C's—choice, competence, communication, compassion, continuity, and (no) conflict of interest.

*To obtain a copy of the report, call Medical Alley at 612/542-3077.



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The article describes how managed care may undermine each.

Managed care plans limit their enrollees' choice of physician and access to specialists and certain procedures. Employers often offer only one plan with a limited physician network, and it may be expensive to go outside the network. Utilization review decisions may overrule choices made by the physician and patient.

Competence may be compromised when health plans pressure primary care physicians or even non-physicians to manage patients who should be referred to specialists.

Communication and compassion may be undermined if physicians are pressured to see too many patients in too short a time, or to spend too little time with patients and too much time on administrative duties.

Continuity of care may be disrupted in a number of ways. In a competitive market, employers may switch plans from year to year, forcing workers to change physicians. Employees who change jobs may find that their doctors are not included in the new employer's health plan network. And health plans may drop some physicians.

Although managed care companies can jeopardize the physician-patient relationship, they also have the power to help preserve and enhance it. Ideally, managed care companies would pursue the following goals:

- 1) Place patients' interests above all else.
- 2) Promote personal and long-standing relationships between patients and their doctors.
- 3) Value the collaborative relationships between primary care doctors and subspecialists.
- 4) Be committed to caring for the needs of a stable group of patients over a period of time.
- 5) Communicate with patients in terms they can understand.
- 6) Focus on disease prevention.
- 7) Consider high-quality care to be both effective and affordable (cost-effective).
- 8) Measure outcomes to monitor and improve quality of care.
- 9) Base financial incentives on

patient outcomes instead of on quantity of care.

10) Value and support education and research.

Managed care companies that pursue these 10 goals will provide support for the physician-patient relationship and will avoid ethical pitfalls. Physicians who insist on working only with "ethical" managed care companies will truly be on the front lines, defending the profession of medicine during these times of change. MM

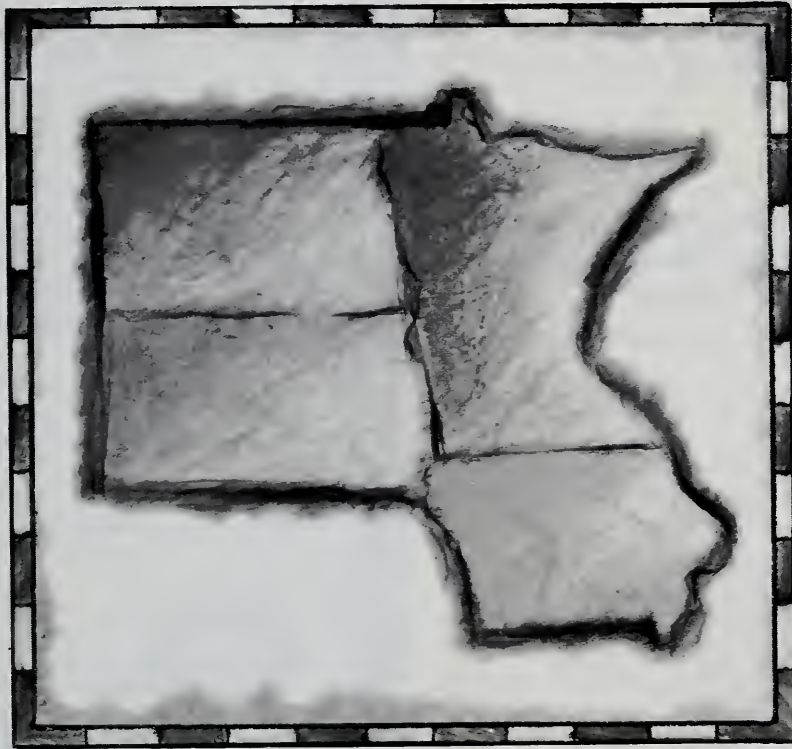
Andrew Smith is past president of the Minnesota Medical Association and a neurological surgeon in private practice in Minneapolis. He is a member of the Allina Foundation board of directors.

Portions of this paper were presented at the symposium, "Managed Care Systems: Emerging Health Issues from an Ethics Perspective," sponsored by the Allina Foundation and the American Society of Law, Medicine and Ethics, held in Minneapolis in June 1995.

REFERENCES

1. Medical Alley Cost-Effectiveness Task Force. Measuring cost-effectiveness: a roadmap to healthcare value. Minneapolis: Medical Alley, 1995.
2. Council on Ethical and Judicial Affairs, American Medical Association. Ethical issues in managed care. JAMA 1995; 273(4):330-5.
3. Emanuel EJ, Dubler NN. Preserving the physician-patient relationship in the era of managed care. JAMA 1995;273(4):323-9.

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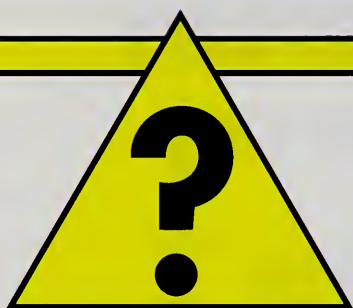
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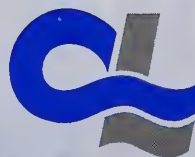
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The Ethical Challenge of Managed Care

A Critique of the AMA's Stance

The AMA's "Ethical Issues in Managed Care" report provides a foundation for establishing ethical standards, but it has some flaws.

Susan M. Wolf, J.D.

The ethics of managed care has become one of the hottest topics in bioethics. Managed care organizations (MCOs) have long been considered important vehicles for controlling costs, promoting preventive care, and, more recently, reforming the health care system. But now the ethical challenges MCOs pose to the physician-patient relationship have taken center stage. And the demand they create for ethics at the level of health care organizations is forcing new thinking.

Bioethics has traditionally treated the physician and patient as an isolated twosome. Largely ignoring the health care delivery system, bioethics has concentrated on preaching the importance of truth-telling, obtaining informed consent, and respecting patient autonomy. The physician has been seen as the patient's protector and advocate, striving to serve the patient's interests.

Recently, however, some ethicists have begun to question this model. They argue that in an era of scarce and expensive health care resources, doing everything therapeutically beneficial for a patient is no longer desirable. It might be better to forgo expensive interventions, such as a liver transplant for an elderly patient, in favor of basic care for a much larger number of patients. Physicians, they suggest, should consider not just the patient at hand, but the population being served by the health care organization.

The biggest challenge to the tra-

ditional model, however, is posed by managed care. Although MCOs take many forms, they commonly abandon fee-for-service compensation in favor of meeting the comprehensive health needs of a population for a set fee. Physicians providing primary care generally act as gatekeepers, deciding what treatments to order and whether to refer patients to specialists. These decisions are typically subject to utilization review. MCOs may also provide financial incentives to mold physicians' practice styles, such as by withholding a portion of compensation that is reduced with each referral or hospitalization before the sum left is paid to the physician.

All of this creates pressure for physicians to depart from the traditional advocacy model, which calls for doing everything therapeutically beneficial for the patient. Instead, it encourages physicians to feel accountable to groups of patients and to the health care organizations within which they practice. Physicians faced with these incentives are supposed to think twice before referring, hospitalizing, or ordering expensive tests.

This incentive structure has understandably caused concern among physicians, patients, and ethicists. How should physicians balance the traditional obligation to serve the individual patient with the duty to conserve health care dollars for the patient population and the health care organization? What should physicians do if appropriate treatments are not approved by utilization re-

view? When should physicians consider their own financial self-interest and the incentives penalizing them even for treatments they regard as therapeutically warranted? And where does the MCO fit in this picture—are some incentives, compensation plans, and structures simply unethical?

Until recently, the literature on these issues was relatively sparse* and advice from the leading professional societies not very specific. Both the American College of Physicians and the American Medical Association (AMA) urged physicians to place their patients' needs above all other considerations.¹ But neither delved deeply into the problems posed. In addition, they said little about what would constitute ethical behavior by an entire health care organization.

THE AMA TAKES A STAND

That gap is now being filled. In January 1995, the AMA's Council on Ethical and Judicial Affairs published the report, "Ethical Issues in Managed Care" (see sidebar, page 30), in the *Journal of the American Medical*

*However, for important work that predates the AMA Council on Ethical and Judicial Affairs' Report, "Ethical Issues in Managed Care," see, for example, "Medicine, Money and Morals" by Marc A. Rodwin (Oxford, 1993) and "Balancing Act: The New Medical Ethics of Medicine's New Economics" by E. Haavi Morreim (Kluwer, 1991).

Association.² It was accompanied by two other articles.^{3,4} Less than two months later, the *New England Journal of Medicine* published its own cluster of articles,⁵ and other articles have since followed.^{6,7} What started as a trickle of commentary has now swelled to a river.

Although criticized for some weaknesses, the AMA council's report is important because it provides a foundation for analyzing ethical issues in managed care, and the council is using the framework to formulate further advice.

The council offers ethical guidance first to physicians and then to health care organizations. On the first score, in keeping with past AMA positions, the council states that physicians have a unique set of obligations to patients. Because physicians know patients' needs, can advocate for patients, and have patients' trust, they must place patients' interests

first and act as agents for patients alone. But the council acknowledges that physicians face conflicting loyalties, namely the needs of other patients and their own financial self-interests. The council overlooks a third source of conflict, the interests of the health care organization itself.

Despite these conflicts, the council urges physicians to remain loyal to individual patients. Thus, physicians should not engage in "bedside rationing," denying beneficial care to any one patient to conserve resources for the broader group. The council argues that bedside rationing leads to decisions that are inconsistent, uninformed, and contrary to the duty of loyalty to the patient. Instead, allocation decisions should be made according to guidelines set at a higher policy level.

Second, physicians "should disclose all available treatment alternatives ... including those potentially

beneficial treatments that are not offered ... under the ... plan." Here the council is rejecting the argument that health plan subscribers agree to plan limits on available treatments and, therefore, need not be informed of uncovered treatment options. This argument—that plan subscription alters later obligations to obtain informed consent—is indeed flawed. Subscribers may not fully understand what treatment options they are giving up until those treatment options become truly germane. Patients should be fully informed so they may consider seeking the treatment off-plan or challenging the health plan when it denies coverage of a benefit.

Third, the report says physicians should advocate for patients' getting treatment that would provide "material benefit" and should initiate appeals on behalf of patients when benefits are denied. This is a pivotal claim, given the controversy over

ETHICAL ISSUES IN MANAGED CARE: AMA RECOMMENDATIONS

The American Medical Association's Council on Ethical and Judicial Affairs has adopted the following guidelines addressing potential conflicts of interest physicians may encounter under managed care arrangements:

1. The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first.

2. When managed care plans place restrictions on the care that physicians in the plan may provide to their patients, the following principles should be followed:

- (a) Any broad allocation guidelines that restrict care and choices—which go beyond the cost-benefit judgments made by physicians as a part of their normal professional responsibilities—should be established at a policymaking level so that individual physicians are not asked to engage in ad hoc bedside rationing.

- (b) Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients.

- (c) Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create structures similar to hospital medical

staffs that allow physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs.

- (d) Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, i.e., denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise in which a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan's policymaking level to seek an elimination or modification of the guideline. Physicians should assist patients who wish to seek additional appropriate care outside the plan when the physician believes the care is in the

whether a physician should seek to provide all care that may benefit the patient, no matter how unlikely or slim the benefit. Unfortunately, the report does not define the term "material benefit" or explain how it differs from terms such as "marginal benefit." This creates a considerable hole in the report.

Finally, the council says physicians should not participate in plans that encourage or require care at less than professional standards. This relates to the council's recommendations for health care organizations. The report condemns certain institutional arrangements that encourage substandard care and erode patient trust.

This, in fact, is probably the most controversial part of the report. In addressing the ethical obligations of health care organizations, the council condemns financial incentives for physicians to withhold medically

necessary care. Thus, the council deems fee withholds and other incentives that penalize physicians for referring or hospitalizing patients, regardless of how necessary, as unethical. The council says financial incentives are acceptable only if designed to promote cost-effective care.

In addition, the council says institutions should place limits on fee withholds, bonuses, and other incentives in order to limit their power to influence physician behavior. The proportion of compensation at risk should not be too great, and the penalty or reward should be calculated on the basis of group behavior rather than one physician's actions. It is also preferable to calculate incentives yearly rather than monthly, so that resources consumed by an expensive case can be balanced by other cases over the year.

Finally, the council says patients should be fully informed about these

incentives at enrollment and at least annually thereafter. However, the report does not suggest how this information can be effectively communicated. Recent controversy over clauses in physicians' HMO contracts that constrain communication with patients ("gag clauses") suggests that in advocating openness, the council has focused attention on an important concern, not only in the physician-patient relationship, but also in the plan-subscriber relationship.

PRAISE AND CRITICISM IN THE LITERATURE

The AMA report has garnered attention both for its strengths and weaknesses. Ethicist Edmund Pellegrino, M.D., has praised the report for "the moral validity of ... [its] central theses." He writes that he "agree[s] with ... its emphasis on the primacy of the physician's obligation to his or her

patient's best interests.

(e) Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan.

(f) Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate or whether they wish to seek care outside the plan for treatment alternatives that are not covered.

(g) Physicians should not participate in any plan that encourages or requires care at below minimum professional standards.

3. When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at

risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.

(a) Any incentives to limit care must be disclosed fully to patients by plan administrators on enrollment and at least annually thereafter.

(b) Limits should be placed on the magnitude of fee withholds, bonuses, and other financial incentives to limit care. Calculating incentive payments according to the performance of a sizable group of physicians rather than on an individual basis should be encouraged.

(c) Health plans or other groups should develop financial incentives based on quality of care. Such incentives should complement financial incentives based on the quantity of services used.

4. Patients have an individual responsibility to be aware of the benefits and limitations of their health care coverage. Patients should exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs.

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patient."⁸ The AMA council itself has issued a subsequent statement on the ethics of using drug formularies to contain costs, building on the report and again using the notion of "materially" beneficial care.⁹ Further work is under way at the AMA on the ethics of "gag clauses" and other issues in managed care.

The report has also drawn criticism. Although it clearly offers an important look at a difficult set of ethical problems, it fails to provide a completely adequate answer. It does not clarify the central concept of "material benefit." Nor does it provide much help in operationalizing its recommendations; it never says, for example, how "cost-effective" incentives should be structured.

Finally, it does not adequately engage other viewpoints in the literature to show why some arguments are rejected and others embraced. Haavi Morreim, for instance, argues that the physician's proper role is to cooperate with resource rationing while advocating for individual pa-

tients,¹⁰ and Mark Hall says physicians should indeed engage in bedside rationing.¹¹ The report would have been stronger had it more fully addressed the work of such thinkers.

CONCLUSION

In truth, no one document can resolve the ethics of managed care. The problem challenges the entire field of bioethics. We can no longer look at the physician and patient in isolation. Instead, we must analyze the system in which care is rendered, determine how the physician fits into that system, and specify what obligations health care organizations themselves have. Most importantly, we must figure out how individual subscribers and patients can navigate these systems with full information and a caring, committed physician at their side.

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ACKNOWLEDGMENT

The University of Minnesota Center for Biomedical Ethics offers bibliographies and other resources on the

ethics of managed care, to which this article is indebted.

Susan Wolf is an associate professor of law and medicine at the University of Minnesota Law School and a faculty associate at the University of Minnesota Center for Biomedical Ethics in Minneapolis.

REFERENCES

1. See the discussion in: Wolf SM. Health care reform and the future of physician ethics. *Hastings Cent Rep* 1994; 24(2):28-41.
2. Council on Ethical and Judicial Affairs, American Medical Association. Ethical issues in managed care. *JAMA* 1995;273:330-5.
3. Clancy CM, Brody H. Managed care: Jekyll or Hyde? *JAMA* 1995;273:338-9.
4. Dubler NN, Emanuel EJ. Preserving the physician-patient relationship in the era of managed care. *JAMA* 1995;273:323-9.
5. See, for example: Rodwin MA. Conflicts in managed care. *N Engl J Med* 1995;332:604-7.
6. See, for example: Woolhandler S, Himmelstein DU. Extreme risk—the new corporate proposition for physicians. *N Engl J Med* 1995;333:1706-8.
7. See, for example: Kassirer JP. Managed care and the morality of the marketplace. *N Engl J Med* 1995;333:50-2.
8. Pellegrino ED. Interests, obligations, and justice: some notes toward an ethic of managed care. *J Clin Ethics* 1995;6:312-7, at 312, 316.
9. Council on Ethical and Judicial Affairs, American Medical Association. Managed care cost containment involving prescription drugs. In: Council on Ethical and Judicial Affairs. Code of medical ethics: reports. Chicago: American Medical Association, 1995:71-81, at 76.
10. Morreim EH. Balancing act: the new medical ethics of medicine's new economics. Norwell, Massachusetts: Kluwer Academic Publishers, 1991.
11. Hall MA. Rationing health care at the bedside. *New York University Law Review* 1994;69:693-780.



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MEDPAC Kicks Off its Membership Drive

As part of Action '96, MEDPAC, the political action committee of the Minnesota Medical Association, has launched a membership drive in preparation for one of the most important elections in recent years. In November the entire Minnesota Legislature, all eight members of Congress, and one of Minnesota's two U.S. Senators are up for reelection. Twenty-one of the state's 201 lawmakers have already announced that they will not return to the Capitol next year.

"The number of open seats offers us a tremendous opportunity to set the direction of the new Legislature," said John Dowdle, M.D., chair of the MEDPAC Board of Directors. "I strongly urge every MMA member to join MEDPAC and help us make an impact on the '96 elections." A sustainer MEDPAC membership is \$150, and a regular membership is \$95.

MEDPAC supports political candidates in Minnesota who support the MMA's legislative goals and recommends national candidates to

AMPAC, the AMA political action committee. Currently, MEDPAC is beginning the process of endorsing candidates and contributing to the elections of legislators who have supported MMA policies in the past.

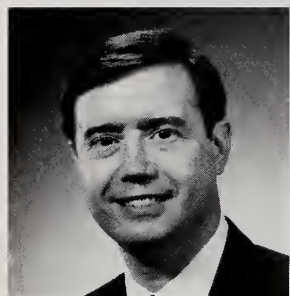
MMA Makes it Easy to Be Politically Active

"Contributing to MEDPAC is extremely important, but it's not enough. We also need grassroots support if we are to achieve the MMA's legislative goals," said David Renner, MMA director of policy and legislation. "Legislators listen to constituents they know personally, especially the ones who have been active in their campaigns."

To encourage MMA members to be active in the 1996 political campaigns and lay the groundwork for a successful grassroots effort, the MMA has put together a slide presentation that will be available for meetings of component medical societies, hospital medical staffs, or other groups. In addition, the MMA has prepared informational packets that include step-by-step instructions on:

- how to become involved in a political campaign—from hosting a fundraiser to pounding in lawn signs;
- how to communicate effectively with your legislator—what to say and what not to say; and
- how to become a knowledgeable advocate—talking points on key MMA issues.

For more information, call Wendy O'Donnell at the MMA, 612/378-1875 or 800/999-1875.



Viewpoint

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Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

What Is Our Role in the Reformed Health Care System?

It takes a village to raise a child" has become a popular phrase lately. It seems relevant to the changes in health care that have taken place in the newly integrated systems. Many of us are no longer practicing independently and making all the decisions. You could say: "It takes a team to cure a patient."

In treating a person who is suffering from chronic illness, for example, we physicians design the overall approach to managing our patient's care, but we are often part of a team. We interact with many other caregivers such as social workers, nurses, laboratory and x-ray technicians, physical therapists, etc. As team players, we need more than technical expertise and skill in interacting with our patients; we also need the ability to work effectively with other health care providers. We have to know how they fit in our global plan for providing care.

As the number of solo practices dwindles, some of us fear that a loss of power and independence could erode our autonomy and professionalism. But there are opportunities as well. The team approach offers us a chance to be a player/manager like the baseball players who play on the team, and at the same time coach the ball club. Yogi Berra once asked, "How can you think and hit at the

same time?" But, like the baseball player/managers, we physicians are often called to do just that—to provide the day-to-day care for our patients and, at the same time, to coordinate their care. We have to be aware of our patients' needs and work with others to create systems that will serve those needs.

It may not be immediately apparent, however, how an individual physician can have much of an impact, especially within a large health care system. We may have concerns about how specific policies will affect our patients and yet feel powerless to change them.

I don't believe that we have to accept flaws in a system; we can work with others to change the system. We can avoid the temptation to take an "us vs. them" approach, pitting physicians against health plans or creating divisions of labor. Instead we can take ownership of the system.

The first step is identifying: What needs to be fixed? And then figuring out: How can we do things better? The following steps depend on our unique circumstances. We are in different practice arrangements and have different interests. Our own particular way to become part of the solution will vary. There are opportunities within our health care system or hospital as well as through

the Minnesota Medical Association and political activities.

Ways to Affect Health Care Policies

Some specific examples of how to exert influence come to mind:

- Become actively involved in developing practice parameters and setting the standards of practice.
- Develop clinical knowledge in a particular area of interest and offer to serve as a resource.
- Write letters, making specific suggestions for change.
- Become active in the MMA. Serve on an MMA committee or join the MMA Legislative Network.
- Volunteer to serve on a hospital committee.
- Join MEDPAC.
- Become active in politics. Participate in a political campaign and develop a relationship with a legislator. Offer to give advice on health care issues and legislation.

If we are to effect change, we have to develop support for our ideas by talking to our colleagues and building informal networks. Participating in a committee is one way to enlist the support of others, but it also has the potential to extinguish all sparks of interest. It is a pleasure to attend a well-run committee meeting with a clear focus and the right people gathered around the table. The materials have been sent out on time, the participants have read the materials and prepared for the meeting, specific goals have been set. On the other hand, it is extremely frustrating to attend a poorly run committee meeting. We may have to make an effort to ensure that a committee is effective instead of squelching its members' interest.

I believe it is possible to maintain our professionalism in the new world order, but it may require a real effort. We cannot provide all the health care ourselves, but we physicians should take the lead in coordinating our patients' care and in managing the health care systems. • • • • •

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NATIONAL NEWS

DISAGREEMENT OVER MSAs STALLS INSURANCE BILL

The Republicans and Democrats have been unable to agree on the conferees who will iron out differences between the U.S. House and Senate versions of the Health Insurance Reform Bill. There has been a stalemate since April 24, when Sen. Edward Kennedy, D-Mass., and other leading Democrats objected to the conferees proposed by Senate Majority Leader Robert Dole, R-Kan. Democrats contend that the proposed conference committee was weighted too heavily toward the GOP and toward medical savings account supporters. Dole proposed seven Republicans and four Democrats. Kennedy made a counter proposal for a committee of five Republicans and three Democrats, but Dole rejected it. There must be unanimous agreement on the conferees.

The Senate bill is narrowly focused toward health insurance reforms that have bipartisan support, while the House bill includes controversial measures such as tax-deductible MSAs and medical malpractice reform. The AMA strongly supports the House version, arguing that MSAs increase choice, promote responsible spending, and reward the patient for wise expenditures. The AMA also continues to push for medical malpractice reform.

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COLA PROGRAM WILL REDUCE ON-SITE LAB SURVEYS

The Commission on Office Laboratory Accreditation (COLA) has introduced a new Performance-Based Survey (PBS) program, which allows top-quality laboratories to reduce the frequency of their on-site inspections from two years to four years.

To be eligible for the PBS program, COLA-accredited laboratories must have participated successfully in proficiency testing for the previous year, performed at a superior level on their last COLA on-site survey, and not undergone a change in laboratory director or owner.

In lieu of an on-site COLA survey, labs participating in the PBS program complete a self-inspection of their laboratory operations and return the survey to COLA. Their responses and supporting documentation regarding quality control records and quality assurance procedures are evaluated to determine whether they meet COLA standards for accreditation. If a lab's survey is satisfactory, its accreditation is continued and the lab is scheduled for an on-site survey in two years. Laboratories that do not meet the evaluation criteria for the PBS program will be scheduled for a routine on-site survey.

Make a Difference—Join an MMA Committee

..... **SERVING ON AN MMA** committee is an excellent way to keep up-to-date on interesting issues and to voice your concerns and opinions. The MMA benefits greatly from committee members' generous contributions of time and expertise.

The MMA Committee on Bylaws, Committees, and Membership is beginning the process leading to appointment of members of the MMA's standing committees for terms beginning January 1, 1997. The committees are Accreditation and Continuing Medical Education; Administration and Finance; Bylaws, Committees, and Membership; Communications; Ethics and Medical-Legal Affairs; Legislation; Medical Practice and

Planning; Minority Affairs; Professional Liability; Public Health and Preventive Medicine; Women Physicians; and Workers' Compensation.

MMA members are eligible to serve on one committee at a time for a maximum of six consecutive years. Committee terms are for two years except for the Committee on Accreditation and CME, which has a three-year term. Trustee district representation on each committee is based on the total number of members in the district. Most committees meet about four times a year.

The committee appointment process begins when each component medical society nominates candidates from its membership to fill vacancies for the upcoming year. Trustees in

each district review and submit the slate of nominees to the Committee on Bylaws, Committees, and Membership, which nominates candidates for any remaining vacancies and forwards its recommendations to the MMA Board of Trustees for ratification.

In addition, the Organized Medical Staff Section, the Young Physicians Section, the Resident Physicians Section, and the Medical Student Section appoint designated committee members to serve on select committees.

To be considered for appointment to a committee, please call your component medical society or call Jane Phillip at the MMA at 612/378-1875 or 800/999-1875. She can also give you more information about the activities of each committee and about the appointment process.

Rep. Roger Cooper Leaves Minnesota Legislature



After 10 years in the Minnesota House of Representatives, Rep. Roger Cooper, DFL-Bird Island, has resigned. Best known as an advocate for rural health care, Cooper brought the rural perspective to discussions of health system reform, and he helped develop the MinnesotaCare program, the state-subsidized insurance program for low-income working people. He joined the MMA in resisting overly strong state regulation, which he believed would undermine access to care in rural Minnesota.

As he looks back on a decade in the House, Cooper sees three accomplishments that stand out.

1) Early in his House term, Cooper helped pass funding for a survey in Kandiyohi, Meeker, Ren-

ville, and McCloud counties to find out how many people were uninsured as well as why and how long they had been uninsured.

2) In 1995, Cooper helped pass changes in MinnesotaCare legislation including the repeal of the regulated all-payer option, expansion of MinnesotaCare eligibility, and a ban on the exclusion of patients with expensive needs from health plans. Cooper is pleased with his work on health system reform. "I'm glad to know that 90,000 people are getting some type of insurance who would otherwise be uninsured and that there have been small-group insurance reforms," he said.

3) He helped establish the independent board for emergency medical services.

Cooper, who served as chair of the MinnesotaCare Division of the Health and Human Services Committee and on the bipartisan Legislative Oversight Commission, which shepherded through the MinnesotaCare legislation, believes health system reform was a success. "If you look at what we were trying to accomplish 10 years ago with MinnesotaCare and where we are now, we have been very successful," he told *The Monitor*. "We wanted to reduce the cost of insurance, reduce the number of uninsured, initiate small-group reforms, and slow medical inflation. We succeeded. Ten years ago, the cost of insurance was going up 15 percent to 25 percent a year. Now it has leveled or slightly decreased. Minnesota's number of uninsured has remained constant or slightly decreased while the national number of uninsured is rising. Insurance reforms in the small-group market have been successful in improving access."

Cooper will not be at the Legislature during the next round of MinnesotaCare changes, which will involve extending managed care into rural Minnesota, but he does believe that some form of managed care will work. "If you give providers and consumers some choice among options, such as direct contracting, the co-op model, and HMOs, managed care will work in rural Minnesota. Whether a single type of managed care will work, however, is still under debate."

Cooper, along with 20 other legislators, decided to resign after the contentious 1996 session. "Increasingly, in the last year, the Legislature has become more interested in scoring political points than in developing public policy," Cooper said. "Unfortunately 'compromise' has become a dirty word that has come to mean 'sell out.'" Cooper stressed that compromise is essential whenever two or more people are involved in making a decision. "Recently, there has been too much concern with power. When you don't have a vision of where you want to go in terms of public policy, you spend too

Cooper continued on page 37

Cooper continued from page 36

much time dealing with power and control.”

Cooper had some parting words of advice for MMA members who want to influence the political process so that high-quality health care remains available throughout Minnesota. “If any person is going to influence—not control—what happens in the Legislature, they should speak with their representative, not screaming and yelling, but giving advice.

“I never claimed to know all the answers,” Cooper said, adding this

tongue twister: “It wasn’t who I knew, or what I knew, but who knew what.” He said, “I felt very comfortable talking to Lyle Munneke and Darrel Carter and some others because they were open and honest,” Cooper said. “I would ask ‘What do you think?’ and they’d tell me their experiences and thoughts, both the ups and the downs. Then of course I had to make the ultimate decision.” (Lyle Munneke, M.D., is a family practice physician from Willmar, and Darrel Carter, M.D., is a family practice physician from Granite Falls.)

“Roger Cooper is viewed as ‘Mr. Rural Health’ in the Legislature,” said David Renner, MMA director of policy and legislation. “His commitment to doing the right thing was evident as he tackled the issues. The MMA is losing a very good friend at Rep. Cooper’s retirement, one who will be hard to replace.”

This fall, Cooper will return to teaching high school social studies, but if somewhere down the road an opportunity arose, he would be interested in working on rural health care issues in the Minnesota Department of Health. • • • • •

M M A N E W S

MMA LEADS IN PUBLICITY

In 1995, the MMA was mentioned more often in *Star Tribune* articles than any other statewide association, finishing ahead of the Minnesota Bar Association and the Minnesota Trial Lawyers Association. In 1994, the MMA finished second among statewide associations, surpassed only by the Minnesota Chamber of Commerce. In the period from 1986 to 1995, the MMA was third in the number of *Star Tribune* mentions, surpassed only by the Minnesota Chamber of Commerce and the Minnesota Business Partnership. Mark Vukelich, MMA director of communications, attributes his success to the relationships he has built with medical reporters.

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BOARD CONSIDERS PHYSICAL THERAPY ASSISTANT RESOLUTION

At the recommendation of the MMA Committee on Medical Practice and Planning, the MMA Board of Trustees decided not to seek legislation that would allow physical therapy assistants to treat patients

without prior physical therapist evaluations when prior evaluation and recommendations have already been made by a physician.

This issue arose in response to a 1995 resolution that was referred to the Board for study. The resolution was originally introduced by Mayo physiatrists. At Mayo, the physician’s order to the P.T. assistant is usually so detailed that another evaluation by a P.T. is generally not needed.

The MMA Committee on Medical Practice and Planning, chaired by James J. Dehen, M.D., noted that under current Minnesota laws and regulations, the physical therapist is responsible for the activities of the physical therapist assistant. The laws prohibit delegating initial treatment responsibilities to P.T. assistants. Therefore, in order to implement the resolution, a change in state law to redefine and broaden the scope of practice of P.T. assistants would be necessary.

Expressing concern that many non-physiatrist physicians might be fairly

general in their P.T. orders, the committee recommended that the MMA not pursue this issue, and the Board agreed.

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MMA STUDIES ITEMIZED BILLING

A 1995 resolution, which was referred for study to the MMA Board of Trustees, called on the MMA to support the provider practice of supplying itemized billing statements to patients, including patients in capitated plans, who request the information. At the recommendation of the MMA Committee on Medical Practice and Planning, the MMA Board of Trustees decided not to support this practice. After much discussion of the advantages and disadvantages, the committee concluded that itemized statements would yield more problems than benefits. The committee noted that with prospective payments and capitated payments, there is no true “cost” associated with each item used in a given service.

Project Read—A Prescription for a Healthy, Active Mind

As part of Project Read, television sets are switched off in the waiting room at St. Paul-Ramsey Pediatric Clinic, and preschool children are listening spellbound as volunteer Bob Bremer reads them a story. Holding up an oversize book, he points to the colorful illustration and reads, "How did the frog get away?" The children yell out, "Jump, frog, jump." Older children and parents seem as delighted as the little ones. On the walls are signs with the project's most important message—"Read to Your Child"—in several languages. When a boy is called in to see the doctor, Bremer reaches into his sack and pulls out a book for him to take home. The boy's eyes light up. "Can I really keep it?"

"Reading to a child isn't just a nice thing to do," according to Robert O. Fisch, M.D., a pediatrician at St. Paul-Ramsey Hospital and the University of Minnesota, who initiated Project Read. "It's as important for a young child's developing brain as nourishing food is for the body."

MMA Endorses Project Read

The MMA Board of Trustees has endorsed Project Read, which began at Ramsey Pediatric Clinic two years ago and has recently been introduced at University Hospital.

Fisch, a contributor to *Minnesota Medicine* as an artist and writer, developed the idea for Project Read after he noticed his young patients were glued to the television in the pediatric waiting room. To break the TV's spell, he brought in an armload of magazines for the children to read.

"They'll just take them home," the nurse told him.

This planted an idea. Why not? Why not encourage children to read by letting them read magazines in the waiting room and then take them home? The next step was to have volunteers read to the children. Now,

as an optional part of Project Read, children are given a free book as a gift.

The Developing Brain Needs Stimulation

"The most important thing we can do for our children is give them early stimulation and education," Fisch said. Providing a stimulating environment for infants and toddlers is crucial because the cortex and the pathways in the brain that determine intelligence are formed in the first few years of life. Fisch tells parents they should talk and read to their babies, as well as giving them visual stimulation, such as mobiles and toys, before the children begin to walk. According to findings presented at the 1995 annual meeting of the American Association for the Advancement of Science, if stimulation does not occur in the first four years of life, the child will never reach his or her potential intelligence. "Pro-

grams like Head Start are very good, but they are often too little too late," said Marty Smith, coordinator of the Center for Early Education and Development at the University of Minnesota.

"When I told parents they should begin reading to their babies when they are two to four months old, they looked at me as if I'd asked them to buy them diamonds at Tiffany's," Fisch said. "Many parents don't even have books in their house. But now after we have set up Project Read, people know what I'm talking about. They bring books into the exam room. This is something very simple and very important they can do for their children."

Physicians can play a vital role in teaching parents how important it is to read to their children at a very young age. "This is an opportunity to help children live up to their potential," Fisch said. "We can't do everything. But we can call parents' attention to this incredible tool they have in their hand and urge them to use it. We can encourage them to read to their children."

Read continued on page 39

How to Set Up Project Read

..... TO SET UP PROJECT READ, A hospital or clinic needs to take just a few simple steps:

- Designate a special place in the waiting room as the reading corner.

- Recruit volunteers. The local hospital volunteer service is a good starting point. School teachers, retirees, church members, or family of the clinic staff may wish to volunteer.

- Appoint a volunteer coordinator to arrange schedules, gather books, and train volunteers.

- Gather books from the library or book stores. A children's librarian can help choose appropriate books and may give tips on how to read to groups of small children.

- Set aside a time when there

are likely to be small children in the waiting room.

- Your project may donate free books to the children, but this is not necessary.

Information Is Available

To obtain a Project Read brochure, call Beth Hoheisel at the MMA, 612/378-1875 or 800/999-1875, or Robert O. Fisch, M.D., 612/624-7627.

For information about research on the importance of reading or about early childhood education and development, call Marty Smith, M.A., at 612/625-2898.

For advice on volunteer recruitment or training, call Janice Kissner, 612/221-2716 or Constance O'Hara, 612/646-5411.



Bob Bremer, a retired engineer who has volunteered for Project Read for a year and a half, finds reading to the children a very satisfying experience. "The children are appreciative, and I'm amazed at how much their parents enjoy it, too."

Read continued from page 38

Volunteers Make the Program

"The crux of the program is the volunteers," said Fisch. "It's not hard to find them. This is an easy and rewarding way for busy people to make a difference. It only takes an hour or two."

In a large hospital, such as St. Paul-Ramsey, recruiting volunteers is part of the hospital's volunteer process, according to Janice Kissner, director of volunteer services for Ramsey Medical Center. Publicity also helps in the search for volunteers. After KARE-11 TV broadcast a news feature on Project Read, volunteers called, eager to join. "When the project is launched, it's a good idea to notify local reporters and radio personalities," said Constance O'Hara, director of volunteer services for the University of Minnesota Health System. ♦ ♦ ♦ ♦ ♦

ANNOUNCEMENTS

AMA PHYSICIANS PRACTICE SALES PUBLICATION IS AVAILABLE

The AMA publication, "Physician Practice Sales: What Every Physician Should Know" by Michael A. Anthony, J.D., and Michael Besney, J.D., is available from the MMA. This publication will be helpful to physicians who are being approached by physician clinics, hospital systems, insurers, proprietary management companies, or other health care providers that are trying to acquire physician practices and/or employ physicians. Determining whether to sell a practice and accept employment with an acquir-

ing entity is difficult. This publication may be helpful. If you would like a copy, please call Elise Arwick at 612/378-1875 or 800/999-1875.

CALL FOR ETHICS PAPERS

The Center for Biomedical Ethics at the University of Minnesota is soliciting papers for its conference on end-of-life health care in managed care November 1 to 2 in Minneapolis. Papers are solicited in the following categories: ethical analysis, clinical services, and policymaking. Papers should be submitted by

August 1, 1996. For more information, call Candace Holmbo, 612/626-9756.

MIDWEST INTENSIVE BIOETHICS COURSE

The 1996 Midwest Intensive Bioethics course will be held July 14 to 19 at the Riverwood Conference Center in Monticello. For information about the conference, call the Center for Biomedical Ethics at the University of Minnesota, 612/626-9756.

MINNESOTA NEWS

MINNESOTA MOVES TOWARD ELECTRONIC DATA INTERCHANGE

Commissioner of Health Anne Barry has formally recommended use of the *Minnesota Implementation Guide for the American National Standards Institute's ASC X12 "837" Health Care Claim*. This guide was developed to provide a single standard method of implementing the ANSI electronic transaction sets.

If you use electronic data interchange (EDI) to submit or accept claims, then effective November 1, 1996, you must be able to submit or accept the ANSI ASC X12N 837 claims transaction set. You are not required to use the *Minnesota Implementation Guide*, but the commissioner encourages you to use it to help reduce the number of different formats for claims transmission.

If your organization does *not* use EDI to submit or accept claims, this notice will not affect you. Nothing in the Health Care Administration Simplification Act requires health care payers, providers, or employers to use EDI or to have the capability to do so.

For a free copy of the *Minnesota Implementation Guide for the ANSI ASC X12 "837" Health Care Claim*, write Denine Casserly, Minnesota Department of Health, PO Box 64975, St. Paul, MN 55164-0975, or call her at 612/282-5650.

If you have questions about the implementation guide or the Health Care Administrative Simplification Act of 1994, call Kathleen Kuha at MDH, 612/282-3822.

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Is EDI RIGHT FOR You?

"If your organization is not currently using electronic methods to transmit claims, this might be an appropriate time to evaluate if EDI is right for your organization," writes Anne Barry, commissioner of health, in a notice recommending use of the new EDI guide.

According to Barry, EDI offers significant savings compared with paper claims transactions both in the costs of sending the claims and in the time required to process and pay them. Implementing EDI may, however, be a complex task requiring hardware, software, and communications.

Help is available. The Minnesota Center for Healthcare EDI (MCHE) has developed a set of EDI training courses and has established a resource center. Courses include:

- Introduction to Healthcare EDI;
- Implementing Healthcare EDI;
- Standards and Mapping; and
- Integration and Testing.

MCHE's resource center is available to help you with any aspect of EDI implementation. For further information, call Patrice Thaler at the Minnesota Health Data Institute, 612/228-4381.

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RURAL HEALTH GRANTS AWARDED

The Office of Rural Health and Primary Care awarded \$200,000 in grants to allow health care organizations to develop networks in rural and medically underserved areas of Minnesota. Grants have been awarded to the following organizations: the Quality Health Alliance in Mankato to develop a strategic plan and hire a medical director; Minnesota Rural Health Cooperative in Willmar to hire a medical director and train cooperative members and staff; the Southwest Health Alliance in Lucerne to set up a regional link in collaboration with public health agencies; the Rural Health Alliance to integrate the communities of Long Prairie, Elbow Lake, Starbuck, and Sauk Center into the Minnesota Rural Health Cooperative; Itasca Dental Providers in Grand Rapids to start a dental cooperative; and the

Northwest Health Alliance to develop its programs.

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MINNESOTA APPROVES GOLDEN RULE MSAs

The Minnesota Department of Commerce has approved a form of medical savings account to be offered by Golden Rule Insurance Company. The plan combines an MSA with a high-deductible health insurance plan. Under current law, MSAs will not receive preferential tax treatment, but Republicans in the U.S. Congress are pushing for changes in the law.

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GOVERNOR NAMES BMP MEMBERS

Gov. Arne Carlson has appointed Barbara Letourneau, M.D., of St. Paul and Scott Tongen, M.D., of Woodbury to the Minnesota Board of Medical Practice replacing Richard Ivance, M.D., and Paul Spilseth, M.D.

The Monitor

JUNE 1996

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1996 Vehicle Leases**

Make/Model	MSRP	Your Price*	24 Mo	36 Mo	48 Mo	60 Mo
Honda Accord 4Dr LX	\$20,235	\$18,526	\$328	\$282	\$261	\$249
Toyota Camry 4Dr LE	\$21,938	\$19,544	\$322	\$281	\$264	\$265
Ford Taurus 4Dr LX	\$22,390	\$20,600	\$397	\$383	\$341	\$326
Chevrolet Suburban 4x4 LS	\$35,838	\$32,819	\$510	\$460	\$422	\$399
Dodge Grand Caravan LE	\$28,030	\$25,689	\$519	\$436	\$392	\$373
Toyota Corolla 4Dr DX	\$18,210	\$16,288	\$291	\$255	\$267	\$244
Ford Explorer XLT 4Dr 4WD	\$28,860	\$26,225	\$446	\$391	\$354	\$327
Honda Civic 4Dr LX	\$16,445	\$15,149	\$234	\$214	\$198	\$203
Mercury Sable LS	\$22,780	\$21,075	\$409	\$393	\$354	\$336
Jeep Grand Cherokee Laredo	\$30,412	\$27,953	\$518	\$434	\$390	\$349

* Sale price before tax, license, and license fees. Prices and lease rates are subject to change due to adjustments made by manufacturers and finance companies.

** All lease payments listed above are monthly lease payments before tax on factory ordered leases. These lease payments are based on a \$0.00 cap reduction and 15,000 miles/year. The only moneys needed to start the above leases are first payment, security deposit, and license for the first year.

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Physician Detection of Family Violence

Do Buttons Worn by Doctors Generate Conversations about Domestic Abuse?

Lisa Bolin, B.S., and Barbara Elliott, Ph.D.

ABSTRACT

Family violence is ubiquitous in our society and, thus, is encountered in all medical practices. The purpose of this study was to ascertain whether physicians wearing buttons with an anti-abuse message have more conversations about violence compared with physicians not wearing such buttons. Six of 11 family practice residents wore Minnesota Medical Association buttons that invited conversations about abuse. For four weeks, all 11 residents recorded daily the number of conversations about violence that occurred in the medical setting. Analyses comparing the two groups showed that the physicians wearing buttons had significantly more conversations than those not wearing buttons ($\chi^2=9.040$, $p<0.005$). Physicians wearing buttons had a higher percentage of days with conversations about domestic violence than physicians without buttons ($\chi^2=7.695$, $p<0.01$). From the significant p-values documented, we conclude that wearing the buttons increases conversations about family violence and makes physicians more consistent in talking about violence with patients.

Family violence has long been a part of our culture, but only during the tenures of the past three surgeon generals has it been brought to national attention. It is now defined to include physical, emotional, and sexual abuse. Violence occurs between adult partners, adults and children, as well as the elderly and their caregivers. Victims of all ages are equally powerless; however, women make up 95% of the victims abused by their partners and, therefore, need special attention.¹

Physicians should be concerned for numerous reasons. Besides concern for their patients' well-being, physicians should also be aware that abuse increases medical costs because of the injuries inflicted and the psychosocial problems that victims can develop.^{1,2} Physician intervention can help to defray these medical costs.

Despite recent intervention campaigns, family violence remains a significant health problem, taking its toll on our patients as well as health care dollars. Studies of emergency department visits have found that, regardless of the complaint, 22% to 35% of all women treated were in the emergency department as a result of partner abuse.³ In order to combat this epidemic, physicians must be willing and able to diagnose domestic abuse. The AMA's Council on Scientific Affairs recommends that "training on interview techniques, risk assessment, safety planning, and procedures for linking to resources be incorporated into undergraduate, graduate, and continuing medical

education programs."³ Screening protocols have dramatically improved detection rates of partner abuse, but, unfortunately, these protocols are not implemented in most practices.⁴⁻⁶

Whether or not a specific screening protocol is in use, physicians must encourage their patients to be open and honest about domestic abuse. This can be difficult, since victims may be embarrassed and may feel responsible for the abuse.² To overcome this obstacle, David Gordon White, M.D., began wearing a button in his Canadian practice that read, "There's no excuse. WIFE ASSAULT. It is a crime."⁷ Although Gordon didn't keep statistical data, he believed that the button encouraged patients to come forward and discuss the abuse they had experienced.⁷

The purpose of the study reported here was to ascertain whether physicians who wore a similar button with a message about family violence (see above) would have significantly more conversations with patients about violence compared with physicians who did not wear such a button.

METHODS

We invited second- and third-year family practice residents to participate in a research project about family violence that included a training session followed by a month of data collection. The training was offered on two consecutive evenings, with six residents present on the first night and five present on the second, for a total of 11 participants—eight of them women. Seven were second-year residents and four were third-



year residents.

An advocate from the Duluth Women's Coalition conducted the information sessions, which lasted approximately two hours each night. The sessions provided a broad introduction to domestic violence, including a discussion of the cycle of abuse and the isolation victims experience. The advocate also addressed the physician's role in diagnosing and treating victims, including screening for abuse, identifying clinical signs of abuse, maintaining confidentiality, documenting abuse in the medical record, intervening and planning for patients' safety. Local laws and resources were reviewed, and a list of referral contacts was given to all the residents, as was an information packet that elaborated on the evening's topics.

At the end of the session, we gave residents consent forms for participation in the study. Six of the consent forms had the word "button" written on the last page, randomly designating who would wear the button during the next month. We gave these six residents buttons printed by the Minnesota Medical Association that read: "It's OK to talk to me about family violence and abuse." We asked all 11 residents to monitor the number of times family violence was addressed in their practices, regardless of button status, and to submit the information to the investigator weekly.

We instructed the residents how to complete the record cards, documenting the number of conversations about domestic abuse they had each day, the location of the conversations (hospital, clinic, ED, or other), and whether they were wearing a button that day. The record cards were given out weekly for four weeks via the residents' mailboxes and were collected in an envelope at the Family Practice Center at the end of each week.

We invited the participating residents to attend a follow-up meeting at the study's conclusion to discuss their experiences. Four residents were present at this meeting to share their suggestions and reactions to the study.

RESULTS

We monitored clinic days (Monday-Friday) for four consecutive weeks, noting vacation days for each physician. Results reported include the data collected from the residents as well as the follow-up interviews with them. We analyzed the data using two measurements: "physician days" and "conversation days."

Each day a physician worked was considered a physician day. If, for example, nine physicians were working on a particular clinic day, nine physician days were recorded. These were further broken down into physician days with a button and physician days without a button. Over the duration of this study, there were 170 total physician days; 73 with a button and 97 without a button (see Table 1). Compliance for wearing the assigned button was 92.3%, 87.5%, 57.1%, and 80.0% weeks one through four, respectively.

Each physician day with one or more conversations about violence recorded was deemed a conversation day. For example, if nine physicians

were working on a particular day and eight had one or more conversations about family violence, eight conversation days were recorded. There were 23 total conversation days; 16 with buttons and seven without buttons (see Table 1).

The total number of conversations recorded was 32. Twenty-three of these were recorded by physicians with buttons, and nine by physicians without buttons (see Table 1).

We excluded one physician day from the results as an outlier; one physician recorded an exceptionally high number of conversations the first day of the study (also the day after the training session). This physician remarked that the number was far higher than was normal for her practice.

In the first analysis, the number of conversation days per physician days with buttons was compared with the number of conversation days per physician days without buttons. The resulting chi-square was 7.695, $p=0.0055$ (see Table 2). Physicians wearing the buttons had conversations about family violence on signif-

Table 1

Conversations about family violence held in the medical setting

	Number with buttons	Number without buttons	Total
Total conversations	23	9	32
Days with conversations	16	7	23
Days worked	73	97	170

$\chi^2=9.040$, $p=.0026$

Table 2

Days with conversations about family violence

	Wearing button	Not wearing button
Physician days with conversation	16	7
Physician days without conversation	57	90

$\chi^2=7.695$, $p=.0055$

icantly more days during the month than those who were not wearing the buttons.

For the second analysis, the total number of conversations per physician days with buttons was compared with the total number of conversations per physician days without buttons. The resulting chi-square was 9.040, $p=0.0026$ (see Table 1). The physicians wearing the buttons had significantly more conversations about family violence than those not wearing the buttons.

During the follow-up meeting, residents agreed that the training session provided a good base of knowledge about family violence but suggested that more clinical information would have been helpful. They also voiced a newly recognized need to learn more about the actions a physician should take once abuse has been identified. They suggested that a case-based training session would be a useful follow-up. One resident who had worn the MMA button said the button helped her remember to ask patients about their experiences with domestic violence. She also observed that other staff members were interested in its message and inquired about it.

The residents commented that the white button was hard to see on a white coat and was difficult to read.

DISCUSSION

The null hypothesis presented for this study was that there would be no difference in the number of conversations about family violence between the physicians wearing the button and those not wearing it. This was not the case. As Gordon White assumed from his experience, when physicians wear a button with an anti-abuse message, patients talk more about domestic violence.

Given the small sample size and the limited number of clinical days this project included, the statistically significant p -values of 0.0055 and 0.0026 are remarkable. Clearly, wearing the buttons encouraged conversations about family violence. Our study did not determine who initiated the conversations about violence, nor did it monitor actual disclosure

of violence by patients or the diagnosis of abuse. It simply recorded the discussion of family violence in the medical setting. Conversations may have occurred because the button reminded the physician to ask about domestic abuse, or because patients felt more willing to talk about abusive situations upon seeing the button.

The findings of the study also indicate that the physicians who wore the MMA buttons talked about family violence more consistently than those who did not wear the buttons. They did not just remember for a short time. Rather, they had conversations throughout the entire four weeks of the study. This may be because of greater physician awareness or patients' response to the button. More study is needed to determine why these conversations occurred and how long the increase in conversations would continue. It is possible that conversations about domestic abuse would continue to increase as patients return, see the button's message again, and decide to talk with the physician at a later time.

The Minnesota Medical Association, which prints and distributes the buttons used in this study, began its campaign against family violence four years ago. Working with the American Medical Association, with Susan Hadley of WomanKind, and with the Minnesota Coalition for Battered Women, the MMA developed guidelines for physicians on how to identify victims of domestic abuse, how to screen for abuse during history-taking, and what questions to ask both before and after abuse has been disclosed. The MMA has distributed pamphlets and produced public service announcements for TV, radio, and billboards to increase public awareness of family violence. Their anti-violence campaign has now been expanded to target violence in the media and to promote safe storage of firearms in the home.

The MMA buttons used in this study were first printed one and one-half years ago in hopes of initiating dialogue about abuse in the health care setting. The buttons are approximately 1.5 inches in diameter, with

a white background and blue script (see page 42). The residents who attended the focus group following the study felt that they were difficult to read, especially when worn on a white coat. They recommended the buttons be larger, brighter, and have a simpler message.

RECOMMENDATIONS

Based on the results of this study, we recommend the following for physicians who are practicing in Minnesota. First, training for MDs in screening for, assessing, and responding to family violence is needed in CME settings. This training should include basic information about family violence and its dynamics, as well as information and techniques on how physicians can identify and treat domestic violence in their practices. Physicians must also be well acquainted with community resources available to victims of domestic abuse. We also recommend that physicians wear a noticeable, easy-to-read button with a message about family violence.

Most important, we recommend that physicians keep talking with patients about family violence. Physicians need to ask about violence when they take a patient's history. Increasing the dialogue about family violence will help reduce the problem's tremendous costs to patients and society.

MM

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REFERENCES

1. Marr J. The epidemic of violence: physicians can play a key role in helping stop domestic violence. *Mich Med* 1994; 93(5):34-49.
2. Sassetti MR. Domestic violence. In: Elliott BA, Halverson KC, Hendricks-Matthews M, eds. *Primary care*. Vol. 20, No. 2. Philadelphia: W.B. Saunders Co., 1993: 289-305.
3. AMA Council on Scientific Affairs. Violence against women: relevance for medical practitioners. *JAMA* 1992;

267(23): 3184-9.

4. Hamberger LK. Prevalence of domestic violence in community practice and rate of physician inquiry. *Fam Med* 1992;24(4): 283-7.

5. Snyder JA. Emergency department protocols for domestic violence. *J Emerg Nurs* 1994;20(1):65-8.

6. Isaac NE. Emergency department response to battered women in Massachusetts. *Ann Emerg Med* 1994;23(4): 855-8.

7. White DG. Wearing a wife-assault prevention button: impact on a family practice. *Can Med Assoc J* 1991;145(8): 1005-12.

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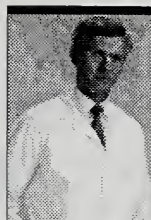
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Why Patients Bypass Rural Health Care Centers

Gerald M. Rieber, B.A., M.S.IV, Daniel Benzie, M.D., M.P.H., and Shawn McMahon, M.D.

ABSTRACT

Many rural health care facilities are financially strained and in danger of closing. One reason is that some patients bypass their local facilities and travel longer distances to urban medical centers for care. We surveyed the residents of two rural Minnesota communities to investigate the factors that draw rural residents to larger urban medical centers. Patient perceptions that bigger is better and that smaller, rural medical facilities are unable to keep up with technology appear to be at the heart of the issue. We asked about residents' attitudes and perceptions of their local health care systems as compared with an urban system. Most rural residents perceive rural primary care physicians as more compassionate and accessible than their urban colleagues; however, many feel rural physicians are less qualified.

Rural hospitals and clinics across the nation are closing because of community environmental factors, hospital environmental factors, and government reimbursement programs.^{1,2} The latter has been extensively covered in the literature, but little has been written about the role of the community in maintaining local hospital viability.

Many community-related factors influence the survival of rural hospitals and clinics. Availability of jobs and industry within a community are important because if residents commute to another city for work, their employer-sponsored health insurance may be contracted with the hospital and clinic in the town where they are employed. Residents from those bedroom communities tend to do less business with local merchants, instead traveling to the urban cities, where selection is greater and prices are often more competitive.

Outmigration of residents for health care has been linked to the perception that communities are not meeting their residents' needs. Factors such as poor quality of care; poor community leadership; inadequate performance by hospital trustees; chronic conflict; and poor teamwork among providers have been cited as the major intra-community factors involved in the failure of rural health care.³ These factors cause residents to lose confidence in the local medical community and seek health care elsewhere.

This begins a series of adverse effects: The hospitals lose revenue and must make cutbacks, and the resulting reductions in staff and services further drive people away and decrease the level of care that the physicians can provide. What follows next is the loss of physicians

because of long work hours and busy call schedules and then sometimes desperate attempts by the hospital to replace them. The shortage of physicians in rural areas means facilities' operating hours must be cut, and vital, costly services such as emergency care must be closed or severely restricted.^{3,4}

Government reimbursement programs have been scapegoated as the primary cause of the rural health care crisis. The Medicare prospective payment system (PPS) and escalating costs of providing health care have been implicated as the major causes of rural hospital closure throughout the 1980s and into the 1990s.^{3,5} The prospective payment system is responsible for some of the financial burden facing rural medical facilities, but community support must also be considered. The decline of rural populations and the migration of many young people to urban areas in search of employment or lifestyle changes have left many rural health care facilities largely dependent on Medicare and Medicaid populations as the major portion of their practice. The resulting drop in income has made it difficult for many rural hospitals to provide for patients' needs.¹ Concern has also been raised over the differential reimbursement policies that favor urban medical centers by reimbursing them at higher rates than rural facilities for the same procedures or services.⁶

Several papers by Adams et al. on Medicare beneficiaries have revealed that severity of illness and distance to a medical facility are major considerations in the patients' choice of hospital. Those with more severe illnesses tend to seek out larger urban or rural hospitals over small rural hospitals. Greater distance to the facility is a significant deterrent for many

elderly patients who prefer not to travel to a larger urban hospital, while younger Medicare beneficiaries are more likely to travel the distance. Existing medical conditions, ability to travel comfortably, or the availability of transportation services often determine where elderly Medicare patients go for care. Adams also found that Medicare patients prefer a hospital with teaching activities.^{7,8} A paper by Buczko states that few rural Medicare beneficiaries leave their local communities for care. Those who bypass do so for three basic reasons: 1) the physical condition of the patient (special needs not available locally), 2) desirable characteristics of more distant hospitals, and 3) undesirable characteristics of the local hospitals.⁵

A study by Bronstein et al. found that a reduced number of rural physicians who offer obstetrics in their practice has driven pregnant patients

to larger facilities.⁹ The study suggests that women choose the hospital where they will receive obstetrical care based on perceived hospital quality (including available technology and competency of the staff) and perceived convenience, cost, and distance. As the distance to the nearest rural hospital providing obstetrical care increased, women were more likely to bypass that hospital in favor of the nearest metropolitan facility.⁸

A great deal of research has been done on the closure of rural hospitals in Minnesota. Most studies have focused on the data that are available based on usage and reimbursement records. The purpose of this study is to examine the attitudes and perceptions of patients in a rural setting and to identify common links between those who choose to bypass their local medical facilities (commuters) and those who remain within the community (locals).

MATERIALS AND METHODS

Two Minnesota locations were chosen for this study: Moose Lake and Two Harbors. Both communities have populations of fewer than 5,000 people, a hospital and clinic, and large rural populations. Two Harbors is located 22 miles north of Duluth, and Moose Lake is located 42 miles south of Duluth.

We mailed a survey to 20% of each community's population as determined by the 1990 census. The names of the survey participants were randomly selected from the local telephone directory.

The survey consisted of 71 subjective and objective questions directed at eliciting the patients' perceptions of their local medical facilities and health care personnel. Ordinal and nominal scale ratings of various topics asked patients to compare their rural and urban expe-

Table 1

Factors influencing choice of health care location

	Locals Mean	Commuters Mean	t-test	p-value
Availability of appointment time	4.118	3.597	3.269	.0012*
Preference for specific physician	4.124	4.528	-2.860	.0046*
Atmosphere of hospital or clinic	4.045	3.603	3.043	.0026*
Availability of specialty physicians	3.933	4.028	-0.612	NS
Location	4.408	2.722	11.764	<.0001*
Availability of services and technology	4.313	4.473	-1.297	NS
Availability of support systems	3.733	3.082	4.038	<.0001*
Other	4.667	5.000	-1.669	NS

Rated on a scale of 1 to 5, with 1=not important and 5=important.

This table shows how respondents rated the importance of various topics to the choice of health care location. Commuters rated availability of a specific primary care physician as the most important consideration. Location was rated highest by local residents and lowest by commuters.

*Statistically significant.

periences and to rate the importance of specific factors concerning where they choose to receive health care. Special needs of patients were considered in

the survey, as were availability and accessibility of transportation.

Survey participants were asked to indicate how confident they are in

their local medical communities based on 1) quality of care, 2) compassion, 3) accessibility, and 4) overall rating. Separate ratings were acquired for physicians, nurses, emergency medical system personnel (ambulance or rescue squad), administrators, pharmacists, and reception personnel. Respondents were asked to compare rural family physicians to urban family physicians, again, based on an overall rating, quality of care, compassion, and accessibility. The survey also asked respondents whether they would use their local or urban health care system for minor and for major (as perceived by respondents) illnesses or injuries.

A series of questions to obtain demographic information was also included. We mailed the surveys in June 1994 and accepted the last response on November 1, 1994. We analyzed the data using descriptive statistics, chi-square, and t-tests using $p < 0.01$ for significance.

RESULTS

We sent 557 surveys to residents of the Two Harbors area, with a return rate of 34.4%, and we mailed 262 surveys to Moose Lake residents, with a return rate of 40.8%—an overall return rate of 35.8% for both communities. Respondents were categorized as commuters or locals depending on where they receive the majority of their health care.

Respondents—59.8% men*—had an average age of 54.7 years and an average of 14 years of formal education. The mean age of respondents was lower for those who bypassed the local community (49.9) than for those who remained locally (56.5, $p = 0.0029$). Gender differences were also significant ($p = 0.0055$), with 21.1% of men and 36.0% of women bypassing their local facilities. Ninety-seven percent of the respondents indicated that they currently had health insurance, and 94.7% had their own transportation. Married persons represented

Table 2

Patients' confidence in the rural medical community

A. Ratings of overall confidence in local medical community (scale 1-10)

	Locals	Commuters	t-test	p-value
Physicians	7.578	5.235	7.482	$p < .0001$
Nurses	8.111	6.493	5.337	$p < .0001$
EMS (ambulance)	8.731	7.742	3.418	$p = .0007$
Administration	7.017	5.508	3.983	$p < .0001$
Reception	7.912	6.508	3.530	$p < .0001$
Pharmacy	8.109	6.918	3.981	$p = .0005$

B. Confidence rating of physicians and nurses in local medical community (scale 1-10)

	Locals	Commuters	t-test	p-value
Physicians				
Quality of care	7.626	4.985	8.479	$p < .0001$
Compassion	7.862	5.516	6.889	$p < .0001$
Accessibility	7.837	6.197	4.689	$p < .0001$
Nurses				
Quality of care	8.098	6.439	5.659	$p < .0001$
Compassion	8.246	6.716	4.880	$p < .0001$
Accessibility	8.226	7.015	3.878	$p = .0001$

A. Members of the community who remain locally for their care demonstrate a higher level of confidence in the medical community than their neighbors who bypass the local facility. Both groups gave EMS personnel the highest rating. Locals gave administration the lowest rating, and commuters gave physicians the lowest rating.

B. Respondents' confidence ratings of physicians and nurses diverged significantly and are reported separately to demonstrate that the population that bypasses the local facility is less confident in the care provided by rural physicians. Notably, however, both groups rate *all* areas as average or above average.

*The distribution may be skewed in favor of men since the source of names for the mailing list was the local telephone directory.

Table 3

Choice of facility in illness or injury

Facility most likely to be used for illness or injury

	Locals		Commuters		Chi ²
	Local facility	Urban facility	Local facility	Urban facility	p-value
Minor	208 (98.6%)	3 (1.5%)	43 (58.1%)	31 (41.9%)	<.0001
Major	94 (45.0%)	115 (55.0%)	4 (5.0%)	72 (95.0%)	<.0001

The majority of local residents will use the local facility for minor events, as would half of the commuters. Only half of local residents would use the local facility for an event that they perceived as major. Few of the commuters would use the local facility for major events.

68.2% of the respondents; 31.8% said they were single, divorced, widowed, or separated.

The survey indicated that 22.6% of respondents who lived within one mile of the local medical facility chose to bypass that facility for care in an urban setting, while those living between two to 10 miles from the local facility bypassed at a rate of 31.1%. No respondents from Moose Lake lived more than 10 miles from the local medical facility.

Seventy-six respondents (27.1%) indicated they had special needs that could not be met by the local medical community. Of those with special needs, 44 (57.9%) said that they would use the services locally if they were made available. There was no significant difference in response between those who left vs. those who stayed in determining use of special needs services.

The respondents were asked to rate the importance of seven factors in determining where they go for health care (see Table 1). Each item was rated on a scale of one to five, with one signifying not important to the decision and five very important. Respondents who remain in the local community for their care rated availability of appointments, hospital or clinic atmosphere, location, and availability of support systems and services as the most important factors. Preference for a specific primary care

physician held more importance for respondents who bypass. There was no difference between the two groups in their response to availability of specialty physicians or to services.

Sixty-five percent of the respondents felt the quality of care in the rural setting was greater than or equal to that in the urban setting. Thirty-five percent felt quality of care was worse in the rural setting. When the groups were considered separately, 74% of the local people felt that the quality of care in the rural community was equal to or better than urban care, while only 38% of bypassers felt that the quality of care was equal or better in the rural community.

Confidence in the local medical community was rated on a scale of one to 10 based on overall confidence, quality of care, compassion, and accessibility (see Table 2). Rural physicians were rated higher for compassion and accessibility than for quality of care and overall confidence. The mean scores increased when the ratings from the commuters were excluded. As one would expect, those who are dissatisfied with the local care go elsewhere. Respondents indicated above-average confidence in the medical community for both rural and urban facilities in this region. However, a lack of confidence does drive some of the rural population toward the larger urban centers, where they feel

more confident.

Respondents perceived rural family physicians as more compassionate and accessible than urban family physicians, but they felt urban family physicians provided higher quality of care. There was a significant difference in the attitudes of locals and commuters about rural family physicians. Thirty-nine percent of commuters, as compared with only 10% of local respondents, felt that rural family physicians are less qualified than urban family physicians; 96.4% of locals and 81.3% of commuters consider rural family physicians more compassionate and accessible.

Most locals, 98.6%, and just over half of commuters, 58.1%, indicated they would use the local medical facility for minor illnesses or injuries. Only 45% of locals and 5% of commuters said they would use the local facility for major illnesses or injuries (see Table 3). (We let respondents determine what constituted a major or minor event.)

The mean age for those who chose to remain locally for their care was 56.5 as compared with 49.9 for the commuters, indicating that older patients are staying locally.

DISCUSSION

Many rural hospitals treat an estimated 30% to 40% of the population available.³ To remain viable, rural hospitals must attract and serve

a larger market share to make up for the losses in Medicare reimbursement and decreased hospitalizations. Most researchers will agree that the Medicare PPS has hurt rural hospitals financially, but some researchers argue that these hospitals could survive if they found a way to attract patients who bypass them.³ The challenge is to determine why patients aren't using their local facilities.

This study revealed that 73.1% of the people surveyed are using their local facilities (compared with 37% in other studies), leaving a relatively small population to target for additional sources of revenue. Included in that small population are those who must travel because they have special medical needs that cannot be met locally. Rural health care facilities must consider whether or not it would be cost-effective for them to provide those special services for just a few patients.

Residents who obtain care locally feel that the quality of that care is equal to or better than the care they would receive in an urban setting. Those who leave the community feel that the quality of care is worse in their community than in the urban setting, and they also have access to transportation. Notably, both groups feel that the medical care in this region is above average for rural and urban systems.

Several respondents gave written comments. One respondent wrote, "Rural doctors could not possibly have enough experience in dealing with asthma patients," so she goes to Duluth for her care. Another commented, "The only reason that doctors are in the rural communities is that they could not get a job in the city." Although some patients must be referred to subspecialists, and some rural physicians, for one reason or another, would prefer not to be in a rural practice, we must reassure patients in rural communities that they are receiving quality health care from qualified, competent, compassionate, and accessible physicians.

STUDY LIMITATIONS

This study surveyed a randomly chosen representative sample of each community but is limited because

participation was voluntary and based on a self-reporting population. The conclusions of this study may be representative of the regional population, but an expanded study should be done to confirm these results. Only two communities were surveyed in northeastern Minnesota. Communities in other regions should be investigated to determine whether these findings apply to other rural areas.

CONCLUSION

Patients' negative perceptions and attitudes concerning the quality of the local medical care foster the out-migration of rural residents to urban centers for care. If rural hospitals and clinics are to remain competitive and viable, they must regain the confidence of those who have chosen to bypass. We must better educate patients on the qualifications and motivations of rural physicians. The first step is to provide accurate information to local residents in order to reduce the misinformation and speculation within the community. **MM**

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REFERENCES

1. Piriani MJ, Hart LG, Rosenblatt RA. Physician perspectives on the causes of rural hospital closure. *J Am Board Fam Pract* 1993;6(6):556-62.
2. Mick SS. Causes of rural hospital closure. *J Am Board Fam Pract* 1993;6(6):612-4.
3. Amundson BA. Myth and reality in the rural health service crisis: facing up to community responsibilities. *J Rural Health* 1993;9(3):176-87.
4. Majeski T. Rural-area health care faces crisis—Wells Hospital to close soon. *St. Paul Pioneer Press* 1992 September 14. Sect. C:1.
5. Buczek W. Bypassing of local hospitals by rural medicare beneficiaries. *J Rural Health* 1994;10(4):237-46.
6. Pate WB. Curing rural health problems is simple: quit the discrimination! *Tex Med* 1991;87(7):6.
7. Adams EK, Houchens R, Wright G, Robbins J. Predicting hospital choice for rural Medicare beneficiaries: the role of severity of illness. *Journal of Health Services Research* 1991;26(5):583-612.
8. Adams EK, Wright GE. Hospital choice of rural medicare beneficiaries in a rural market: why not the closest? *J Rural Health* 1991;7(1):134-52.
9. Bronstein JM, Morrissey MA. Bypassing rural hospitals for obstetrics care. *J Health Polit Policy Law* 1991;16(1):87-118.



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People and Places Making Medical News

People

Orthopaedic Society Officers

James R. Larson, M.D., has assumed the presidency of the Minnesota Orthopaedic Society. Larson is an orthopedic surgeon with Orthopedic Medicine & Surgery and is also chief of staff at Abbott Northwestern Hospital in Minneapolis.

Other newly elected officers include **Steven E. Koop, M.D.**, St. Paul, treasurer; **R. Wynn Kearney, M.D.**, Mankato, president-elect; **Paul C. Matson, M.D.**, Mankato, member-at-large; and **Scott A. McPherson, M.D.**, St. Louis Park, member-at-large.

Pathologist Society Officers

James S. Hernandez, M.D., of St. Cloud, has assumed the presidency of the Minnesota Society of Pathologists.

Other newly elected officers include **Thomas P. Uncini, M.D.**, Hibbing, treasurer; **James C. Strom, M.D.**, Minneapolis, secretary; **Robert M. Kisabeth, M.D.**, Rochester, vice president; and **Virginia Dale, M.D.**, Robbinsdale, director.

Urological Society Officers

John K. Matsuura, M.D., of St. Cloud, has assumed the presidency of the Minnesota Urological Society.

Other newly elected officers include **Michael H. Wipf, M.D.**, Minneapolis, president-elect; **Carl S. Smith, M.D.**, Minneapolis, past-president; **Cesar J. Ercole, M.D.**, St. Paul, secretary-treasurer; and **Michael L. Blute, M.D.**, Rochester, member-at-large.

MAFP Awards

The Minnesota Academy of Family Physicians has named **Ricard Puumala, M.D.**, of Cloquet,

Physician of the Year for his dedication to patients.

David Agerter, M.D., of Rochester, and **Harley Racer, M.D.**, of Minneapolis, were named Teachers of the Year. Agerter, head of the Mayo Family Practice Department and former Mayo Family Practice Residency program director, was recognized as "an effective mentor, an energetic advocate for family medicine issues, and an exemplary role model." Racer, of the Family Practice Department, Hennepin Faculty Associates, was recognized for his "humanistic approach to medical science," including "teaching residents to build strong physician-patient relationships, deal with difficult and angry patients, and be good listeners, teachers, and advocates for peers and patients."

John Myers, M.D., of Canby, received MAFP's Merit Award for his outstanding service to the organization. **Monica Myklebust, M.D.**, of the Mayo Family Practice Residency, was named Resident of the Year for compassionate service to her patients, peers, and community. **Sue Nielsen**, a medical student at the University of Minnesota in Minneapolis, received the Medical Student Award for Contributions to Family Medicine for her support of family practice at the medical school and at state and national levels. And the President's Award went to **Chari Konerza**, director of the Office of Rural Health and Primary Care, for her initiative in establishing rural health programs and assisting rural communities in recruiting and retaining health professionals.

HealthSystem Minnesota Awards

The Institute for Research and Education HealthSystem Minnesota, formerly Park Nicollet Medical Foundation, has given its 1996 Education Award to **Richard C.**

Woellner, M.D., a Park Nicollet Clinic pulmonologist. He was recognized for his role as editor of the *Bulletin*, a quarterly scientific journal published by the institute since 1970, and for his work as a medical writer and lecturer.

Park Nicollet pathologist **George Cembrowski, M.D.**, received the 1996 Research Award, which recognizes individuals whose research is original, consistent with the mission of the institute, applicable to clinical practice, and published in peer-reviewed journals. Preference is given to candidates whose primary function is not research and who have a long-term pattern of research activity. Cembrowski is the author of more than 48 articles published in journals, 82 abstracts submitted to professional societies, and 24 book chapters, monographs, and solicited papers. His research interests focus on laboratory medicine in the areas of quality control and medical decision-making, as well as computerization and automation of laboratory methods and results.

Places

United and St. Kate's to Offer Holistic Therapy Program

Allina's United Hospital is working with the College of St. Catherine to offer college certificate programs in holistic therapies and health and wellness on the hospital campus. The programs will allow health professionals to expand their knowledge in areas that complement traditional medicine, such as Chinese acupressure, massage, healing touch, whole-foods nutrition, and environmental contributors to disease. The goal is to help medical providers become more aware of alternative treatments and to understand when they might be appropriate.

continued

Allina Health System's complementary therapies clinical action group is exploring integration of complementary therapies. Its tentative plans include determining the best practices in complementary therapies, sharing resources across the Allina system, and

looking at credentialing and peer review of complementary therapies.

'U' Receives \$2.5 Million to Help Hospitalized Patients Stop Smoking

Researchers from the University of Minnesota Cancer Center and the School of Public Health have

received a four-year, \$2.5 million grant from the National Institutes of Health to help hospitalized patients quit smoking. Methodist Hospital, St. Paul-Ramsey Medical Center, Hennepin County Medical Center, and Fairview Riverside Medical Center will participate in the research.


"Hospitalization provides a rare opportunity for people to break their addiction to smoking. They can't smoke in their room. They're removed from their usual environmental cues for smoking. And, being sick, they might be more receptive to the idea," said Harry Lando, Ph.D., professor of epidemiology and the prevention program leader for the University of Minnesota Cancer Center. Lando was one of four authors of the 1988 Surgeon General's report on nicotine addiction and recently contributed to the smoking cessation guidelines for clinicians developed by the Agency for Health Care Policy and Research.

An estimated 6.5 million adult smokers are admitted to the hospital each year in the United States. Research shows that these smokers have a strong desire to quit. In one study, 37 percent of patients who smoked prior to the hospitalization attempted to quit, and 16 percent were not smoking a year after discharge.

This study will identify smokers at admission and randomly assign them to one of three programs: minimal intervention, where patients are given a smoking cessation manual; physician intervention, which includes counseling and some provision for follow-up care; and physician intervention plus a nurse counseling session at bedside or by telephone soon after discharge with a six-month follow-up. The study will compare smoking cessation rates one week and 12 months after discharge.

'U' Regents Announce Tax Settlement on Sale of ALG

The University of Minnesota's Board of Regents has agreed on a

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\$1.45 million tax settlement with the Internal Revenue Service concerning the sale of the anti-rejection drug ALG (anti-lymphocyte globulin). The university and the IRS determined that a portion of the profit from the sale of ALG produced taxable income to the university and agreed to a combined assessment of income tax liability and accrued interest. The IRS initially estimated a combined assessment of \$11 million.

"Unfortunately, this settlement is just one more example of the cost to this university of the mismanagement of the ALG program," said Regent William Peterson. "While it is never a happy experience paying back-taxes, especially in this large amount, the Litigation Review Committee of the board is satisfied that an aggressive negotiating posture has achieved the best results possible, given the facts surrounding the ALG program."

In August 1993, after an internal investigation into the ALG program, the university sent a letter of disclosure to the IRS regarding the potential tax liabilities on sales of ALG and requesting a review of the program. The IRS review found that 41 percent of ALG activity over the 22 years of the program was unrelated to university research and, therefore, subject to the unrelated business tax. The university was permitted to offset net losses from other taxable activities against net gains from the ALG program in determining taxable income.

3M Billboard Company Quitting Tobacco Advertising

3M Media is the first U.S. billboard company to quit accepting tobacco advertisements. The company will no longer sign tobacco advertising contracts after December 31, and it will no longer display tobacco ads after 1998.

"It makes a lot of sense given the fact that we're a big player in health care," said 3M spokesperson Mary Auvin. "And the

perception toward tobacco in the health care industry is increasingly negative." 3M made the decision following pressure from company shareholders and customers of its medical products businesses.

Socioeconomics

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program to provide individuals who are eligible for both Medicare and Medicaid with a coordinated program of care that emphasizes primary care. The SeniorCare Dual Program of Medica Health Plans is the first of its kind to receive federal approval. The program will be administered through Medica's Center for Healthy Aging and will be offered to seniors who are enrolled both in Medica's Medicaid and Medicare programs, primarily people who live in nursing homes. The program will begin July 1.

The program will pool Medicaid and Medicare dollars, which will allow health care systems to coordinate services and better assist seniors. Patients will be treated by a care team, composed of a physician and nurse practitioner or geriatric nurse manager working in conjunction with nursing home staff and special services.

The program will contract with EverCare Minnesota, Fairview Partners, HealthEast, and OptAge.

HMOs Enroll 7.7 Million New Members

Health maintenance organizations in the United States added 7.7 million new enrollees during the year ending July 1, 1995, the largest 12-month gain since InterStudy began surveying the industry 17 years ago, according to the company's latest Competitive Edge Industry Report.

As of July 1, 1995, nationwide enrollment in 593 HMOs reached almost 54 million, representing 20.3 percent of the U.S. population (up from 18.1 percent the previous year). Five states accounted for 44.2 percent of the nation's net annual enrollment gains: California, Pennsylvania, New York, Florida, and Oregon.

In the year prior to July 1, 1995, at least 45 new HMOs obtained licenses to offer commercial products. As a group, they tended to be for-profit, IPA-based, independently affiliated health plans.

BCBSM Expanding Partnership With Maine BCBS

Blue Cross and Blue Shield of Minnesota (BCBSM) is expanding its business alliance with Maine Blue Cross and Blue Shield. BCBSM expects the partnership to reduce its claims costs by 20 percent while creating new information-based jobs in Minnesota.

Under the arrangement, the Maine Blue Cross office will assume responsibility for Minnesota's claims examination. Today, 70 percent of the Minnesota plan's claims are received electronically from health care providers. The majority of these electronically submitted claims are processed automatically by the system without any interaction with the claim examiners. The rest of the electronic claims are flagged by the system for additional manual examination because of incomplete information, duplicate claims, and other reasons. The new agreement also calls for Maine to use Minnesota's information systems to process its indemnity claims. The

two offices have developed compatible systems.

The Minnesota and Maine offices have had cooperative ventures since 1992. The Maine plan has relied on BCBSM's computer information systems to process its managed care claims, drawing on the Minnesota plan's expertise with managed care and information systems.

Andy Czajkowski, president and CEO of the Minnesota plan, said the agreement will result in no net job loss at BCBSM. "In fact, we anticipate an increase in higher-skilled, higher-paying jobs," he said.

Rates, Trends, Data

Under-Age Teens Often Able to Buy Tobacco

Under-age teenagers were able to buy cigarettes at more than one-third of the Minnesota stores visited in recent compliance checks conducted by the Minnesota Department of Health and the Minnesota Chapter of the American Cancer Society. Undercover youth, working with adult supervision, visited 914 Minnesota stores over seven months. In communities with strong penalties for merchants who sell tobacco to minors, the teens were able to buy cigarettes in only 21 percent of attempts. In communities without such penalties, the rate jumped to 49 percent.

Selling tobacco to a minor is a gross misdemeanor, but it is seldom enforced against store clerks, and there are no penalties for proprietors, according to a Twin Cities *Star Tribune* article. Several Minnesota communities have enacted penalties, such as fines and license suspensions and revocations.

Among the 19 cities and townships with strong local tobacco laws, the highest rate that teens were able to buy cigarettes was 49 percent. The rate was as high as 100 percent in some communities without strong tobacco laws.

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checks before passage of a local ordinance showed that 50 percent of stores in the town sold to minors. In the latest survey, noncompliance was only 3 percent.

Number of Uninsured Americans Continues to Grow

The number of Americans without health insurance has grown to 42 million, a "foreboding increase" from 39 million just three years ago when President Clinton launched his failed attempt to revamp the American health care system, according to a report by the American College of Physicians (ACP). The group's study attributes the increase in the uninsured to the decline in employer-provided coverage and on funding cuts in Medicaid.

The problem is not restricted to the nation's poor. One-third of the uninsured live in households with annual incomes of more than \$30,000—twice the federal poverty level for a family of four.

In its report, "Universal Coverage: Renewing the Call to Action," the American College of Physicians said declining coverage is a moral and economic issue and urged the presidential candidates and private industry to address it. The ACP also called for public debate to explore alternatives to the nation's employer-based health insurance system.

Medical Research

Cryotherapy Can Prevent Blindness in Premature Infants

Cryotherapy can save the eyesight of premature infants whose eyes become severely diseased, according to a study conducted at 23 centers, including the University of Minnesota. The study, published in the April *Archives of Ophthalmology*, showed that the therapy potentially can reduce the number of premature infants who go blind from 700 to 450 a year. However, the treatment also may limit visual sharpness, according to C. Gail Summers, M.D., director of pediatric ophthalmology at the

University of Minnesota and a study leader.

The study showed that 31.5 percent of treated eyes and 47.7 percent of untreated eyes were blind five and one-half years after treatment. However, 17 percent of untreated eyes were 20/40 or better, compared with 13 percent of treated eyes. Children were considered blind if their vision with corrective lenses was no better than 20/200.

Antioxidant Supplements Won't Win Fight Against Cancer, Heart Disease

Antioxidant supplements—beta carotene, vitamin E, and vitamin C—cannot substitute for fruits and vegetables to help prevent cancer and cardiovascular disease, according to three studies, including one from the University of Minnesota, published in the May 2 *New England Journal of Medicine*.

The University of Minnesota study followed 34,486 postmenopausal Iowa women, assessing their intake of vitamins A, E, and C from food and from supplements to see if their vitamin intake protected them against death from heart disease. During a seven-year period ending December 31, 1992, 242 of them died from heart disease. The women who consumed foods rich in vitamin E had a much lower than average chance of dying of heart disease. Those who avoided the vitamin E-rich foods had about double the heart disease risk as those who ate moderate amounts of the foods. Researchers found no additional benefit for the women who took the vitamin supplements.

In the same *NEJM*, researchers from Harvard reported that a 12-year study of 22,071 male physicians showed that beta carotene supplements offered no benefit or harm in relation to death from cancer, heart disease, or any other causes. Half of the study participants took 50 milligrams of beta carotene on alternate days and half were given placebos.

A third study involving heavy

smokers and asbestos workers was stopped early when it appeared that the participants taking beta carotene and vitamin A were dying faster than similar men and women not getting the supplements. The researchers feared that the supplements were causing harm, but the results were inconclusive. The study intended to research the effects of the supplements on death from lung cancer, heart disease, and other causes.

Meat Linked to Non-Hodgkin Lymphoma

Women who eat large quantities of meat—especially hamburger—have a higher risk of developing and dying from non-Hodgkin lymphoma than women who eat little meat, report scientists from the University of Minnesota and elsewhere in the May 1 *Journal of the American Medical Association*. The study, which included 35,156 Iowa women aged 55 to 69, also found that the women who ate the most fruit had a reduced risk of developing the disease.

The incidence of non-Hodgkin lymphoma increased 73 percent between 1973 and 1991 and is now the fifth leading cause of cancer deaths.

The study divided the women into three categories. The low meat consumption category included women who ate fewer than 34 servings of meat a month; moderate included those who ate 34 to 50 servings; and high consumption was above 50 servings. The study found that women who ate the most animal protein, red meat (especially hamburger), animal fat, saturated fat, and monounsaturated fat had much higher risks for developing the disease. For example, women who had diets high in animal fat had twice the risk of developing non-Hodgkin lymphoma as those with low consumption.

Meanwhile, women who ate more than 84 servings of fruit a month had a 36 percent lower risk of developing non-Hodgkin lymphoma than those who ate fewer than 54 servings a month. ■

LETTERS

continued from page 3

medically managed, medically supervised, intensive outpatient, and office-based services in the CD field.³ ASAM and APA have described clinical pathways for dealing with patients suffering from substance-related disorders and comorbid depression, psychosis, etc.

During the past 20 years, the one obvious and significant achievement of managed care has been the reduction in length of stay for inpatient psychiatric and chemical dependency treatment. With few exceptions, managed care organizations have not advanced the cause of case management and case integration when incorporating practice guidelines. Nor have managed care organizations encouraged the activities of psychiatrists in the ambulatory care setting who are accessible and equipped to evaluate the need for institutional care and/or rationalize interdisciplinary treatment. Instead, psychiatrists are increasingly relegated to the role of medication managers in many managed care organizations.⁴

Sixteen years ago, about 4 percent of Minnesota's 310 psychiatrists worked in salaried HMOs, 26 percent were associated with teaching hospitals, 53 percent were in fee-for-service private practice, and 5 percent worked for the state of Minnesota, with 12 percent postgraduate fellows.⁵ Today, the number of private practicing psychiatrists has decreased dramatically. The penetration of managed care in the greater metropolitan area is estimated to be 80 percent or above, with access to private psychiatrists restricted or eliminated by many of these managed care contracts.

Do we seriously believe that the more effective treatments of mental disorders demonstrated during the past 20 years will lead to the

obsolescence of the field? Can the treatments of the next 25 years be so superior to those of the last 25 years that serious psychiatric disorders can easily be handled by family doctors? Neither primary care physicians nor neurologists will have the time, expertise, interest, or desire to provide skillful clinical and psychotherapeutic management. There will still have to be specialists in the management of mental disorders.

When consumers and others are asked how psychiatrists ought to be part of future health care systems, they usually agree that currently too few psychiatrists are available in the outpatient setting, that integration with other health care providers needs to be improved, and that psychiatric services should not be carved out but should be integrated with other medical services.

I hope that Minnesota physicians will not give up on psychiatrists and allow the carve-out movement to remove us as dues-paying members of the Minnesota Medical Association.

Lee H. Beecher, M.D.

Adult psychiatrist

Minneapolis, Minnesota

REFERENCES

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-IV. 4th ed. Washington, D.C.: American Psychiatric Association, 1994.
2. Treatment guidelines on eating disorders, major depressive disorders, bipolar affective disorders, substance-use disorders (alcohol and opioids), and consultation/evaluation in psychiatry. Washington, D.C.: American Psychiatric Press, 1992-95.
3. Patient placement criteria. Chevy Chase, Maryland: American Society of Addiction Medicine, 1991.
4. Beecher L. Psychiatrist more than medication monitor. *Mental Health Advocate* 1995 July/August.
5. Beecher L. A political analysis of Minnesota psychiatrists and their methods of reimbursement. *Minn Med* 1981;64(6):347-51.

Cutting School Absenteeism

American public schools have been severely criticized for the quality of education they provide to youth. An inordinate amount of school time and resources are spent dealing with dysfunctional behavior—that of both students and parents.

School absenteeism is a significant problem. It is extremely difficult to educate students who are seldom in school. Without quality education and good attendance habits, these young people will become unemployable adults.

Minnesota state law considers students under age 16 truant if they have seven or more unexcused absences. Our high school has students with 50 to 60-plus absences out of 180 school days. It is common for these students to have no significant health problems.

What does this have to do with physicians? The excuse most frequently used by students and their parents is illness. When absenteeism becomes excessive, school staff ask parents to verify health problems with information from a physician. Too often, the information we receive from physicians is not helpful. Sometimes it is extremely vague: "Please excuse this student's absence due to illness." Physicians' notes may address a recent episode of strep or bronchitis, but frequently they do not provide the information we need. Schools generally are not concerned about a brief illness; we are concerned about excessive absenteeism without reasonable explanation.

Very specific health information will help us establish appropriate educational programming. If a student is unable to attend school for an extended time because of an illness, we can establish a home-bound tutoring plan. We need to know:

- the diagnosis;
- the treatment plan (Has the patient been compliant with the treatment plan?);

- any written orders for medications or treatments needed during the school day;
- the frequency of medical visits;
- whether the student is able to attend school on a regular basis;
- whether the absenteeism is justified by the student's health problems; and
- whether any modifications are needed during the school day.

We observe that mental health problems and chemical use account for a great deal of absenteeism and academic underachievement. When performing routine sports physical exams, physicians should ask students about symptoms of depression; amount, frequency, and type of chemical use; school attendance; and academic achievement. Is the student up to date on credits? The more specific the questions, the better information you will receive.

Physicians have a unique opportunity to conduct early intervention with our youth. Schools and physicians must work in partnership to keep our youth healthy, functional, productive—and in school.

*Cheryl L. Vinson, R.N., M.Ed.
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JUNE 1996

June 12-15 **Sixtieth Annual Course on Advances in Trauma and Critical Care Surgery** Department of Surgery, University of Minnesota Medical School; University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, University of Minnesota, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 13-15 **Minimally Invasive Coronary Bypass Surgery Symposium** Minneapolis Heart Institute Foundation; Hyatt Regency, Minneapolis, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

June 17-21 **Summer Institute 1996: Optimizing Health for Older Persons—Practical Strategies** Minnesota Chair in Long-Term Care and Aging, MAGEC, and University of Minnesota Center on Aging; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Steve Daniel or Monica Colberg, MAGEC, School of Public Health, University of Minnesota, Box 197 Mayo, 420 Delaware Street SE, Minneapolis, MN 55455; 612/624-3904.

June 22-23 **The Minnesota Section of the American College of Obstetricians and Gynecologists and the Minnesota Obstetrical and Gynecological Society Spring Meeting** Minnesota Section of ACOG and Minnesota Ob/Gyn Society; Mayo Clinic, Rochester, MN. CONTACT: Jennifer Stendahl, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875.

June 25-29 **Internal Medicine 1996: Advances and Controversies** Mayo Clinic and the Department of Medicine, Royal College of Surgeons, Ireland Medical School; Dublin, Ireland. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

AUGUST 1996

Aug. 2-3 **Bleeding and Thrombosing Diseases: The Basics and Beyond** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Aug. 8-10 **Third Annual Symposium on Biomedical, Biopharmaceutical, and Clinical Applications of Capillary Electrophoresis** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Aug. 16-17 **Point-of-Care Testing and Phlebotomy** Mayo Medical Laboratories; Swissôtel, Boston, MA. CONTACT: Julie McAdams, Mayo Medical Laboratories, Hilton 360, Rochester, MN 55905; 800/533-1710.

Aug. 18-20 **Success With Failure: New Strategies for the Evaluation and Treatment of Congestive Heart Failure** Mayo Foundation; Vail Cascade Hotel & Club, Vail, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Aug. 24 **Phacoemulsification Course** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

June 21 **Infection Control Lecture** Hennepin County Medical Center, Hennepin Faculty Associates; HCMC, Minneapolis, MN. CONTACT: HCMC Continuing Medical Education Office, 701 Park Avenue, Mail Code 869-A, Minneapolis, MN 55415-1829; 612/347-2075 or 888/263-4262.

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

Printed Material: **Physicians' Update: Bloodborne Pathogens** Medical Education Group Learning Systems. CONTACT: MEGLS, Internet address: <http://www.cme.edu>; or call 800/547-0308.

Aug. 24-27 **International Symposium on Radioiodine** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

S E P T E M B E R 1 9 9 6

Sept. 9-10 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Sept. 12-14 **Practical Surgical Pathology Conference in Honor of Louis H. Weiland, M.D.** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Kathy Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, Rochester, MN 55905; 800/533-1710

Sept. 19-20 **Mayo Clinic Update in Hepatology and Liver Transplantation** Mayo Foundation; Hotel Sofitel, Minneapolis, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 19-20 **Sixth Annual Practical Pediatrics Course for the Primary Care Physician** Children's Health Care; Children's Health Care—St. Paul, MN. CONTACT: Mickey Starr, 345 North Smith Avenue, St. Paul, MN 55102; 612/220-6133.

Sept. 19-21 **Echocardiography for the Sonographer 1996: Focus on Myocardial and Valvular Disease** Mayo Clinic; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 21 **Current Concepts in Glaucoma** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Sept. 26-27 **Twenty-third Mayo Clinic Pediatric Days** Mayo Clinic; Radisson Plaza Hotel, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 29-Oct. 4 **Advances in Diagnostic Radiology and Advanced Radiology Life Support** Mayo Foundation; The Broadmoor Resort, Colorado Springs, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

O C T O B E R 1 9 9 6

Oct. 3-5 **Mayo Vascular Symposium 1996: Advances and Controversies in the Multidisciplinary Management of Vascular Disease** Mayo Clinic and North American Chapter of the International Union of Angiology; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Oct. 4 **Insights and Outlooks '96** St. Paul Heart Clinic; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440; 612/992-3826.

Oct. 6-11 **Laboratory Diagnosis of Fungal Infections** Mayo Medical Laboratories; Portland Marriott at Sable Oaks, South Portland, ME. CONTACT: Kathy Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Oct. 11 **Ophthalmic Plastics Course** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 11-12 **Advanced Life Support in Obstetrics** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 12 **Twentieth Annual Current Trends in Ophthalmology Symposium** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 14-16 **1996 International Meeting on ANCA and ANCA-Related Diseases** Mayo Clinic and Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Kay Kenitz, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-8399.

N O V E M B E R 1 9 9 6

Nov. 4-5 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Nov. 9 **Minnesota Society of Pathologists Annual Fall Anatomic Pathology Conference With Steve Silverberg, M.D.** Minnesota Society of Pathologists; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Jennifer Stendahl, MSP, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Nov. 14-16 **Mayo Clinic Ob/Gyn Clinical Reviews** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 23 **Minnesota Society of Neurological Sciences Annual Meeting** Minnesota Society of Neurological Sciences; Radisson Plaza Hotel, Minneapolis, MN. CONTACT: Lisa Deminsky, 22732 132nd Avenue North, Rogers, MN 55374; 612/588-0661.

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., June 15 for August ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Family Practice, Ob/Gyn to join progressive 14-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701.

(*2/96-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439.

(*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674.

(6/95-R)

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(10/93-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439.

(*3/95-R)

Olmsted Medical Center is seeking BC/BE physicians in the following specialties: emergency medicine and family medicine. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. Positions currently open include emergency room and family medicine departments in Rochester and branch office locations. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes nine branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430.

(5/96-R)

Internal Medicine: The Fergus Falls Medical Group's five-member Internal Medicine Department is seeking a BC/BE general internal medicine physician as well as those with subspecialty training/interest in oncology, pulmonology, and nephrology. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066.

(9/95-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine (oncology, pulmonology, and nephrology), family practice, ophthalmology, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066.

(2/96-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916.

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MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277.

(2/93-R)

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Physician Needed to work part time in multidisciplinary clinic. All calls confidential to doctor's private line, 612/889-5973. (6/96-R)

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Family Practice/Pediatrician, BC/BE, to join progressive 28-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographical referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Robert Wilcox, Administrator, Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461, ext. 213. AA/EOE. 3-6/96

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Family Practice Opportunity on north shore—Lake Superior. Primary Care Clinic. Focus: wholeness, prevention, and education. Contact Jon Ward, Bay Area Health Center, 50 Outer Drive, Silver Bay, MN 55614; 218/226-4431.

3-8/96

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Minnesota Medicine

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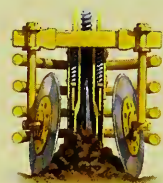
JULY 1996



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same design specifications as municipal systems. Because of these rigid criteria,

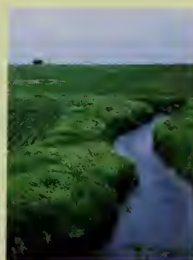
a permitted livestock manure storage facility in Minnesota has never failed.

Minnesota and its farmers continue to be proactive rather than reactive in establishing environmental policies. Our farmers

adhere to some of the strictest and most

rigorously enforced environmental laws

and regulations in the United States.



Grass mound barriers between fields and surface water prevent water contamination.

They need a license to apply most chemicals to their fields. They attend continuing education classes to manage manure.

But behind all the advancements and beyond all the laws is the simple fact that



Farmers have reduced chemical applications to as little as one-sixth of an ounce per acre.

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their families on the land. If they pollute the

groundwater, their children will be the first to drink it.

Environmental irresponsibility is not an option.

Most farmers received their land from their parents. They want to pass it on to their

children. These strong ties to families and to the land are what gave Minnesota agricul-

ture its rich past. They are what will give Minnesota agriculture an even richer future.

MINNESOTA AGRICULTURE 2010

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Minnesota Medicine

Published monthly by the Minnesota Medical Association

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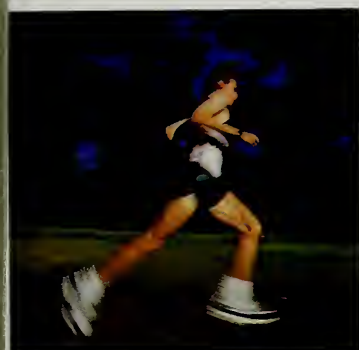
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Some Good Sources on Cross-Cultural Medicine

Thank you for the recent issue covering cross-cultural medicine (May 1996). In the Abbott Northwestern Medicine Clinic, we care for many diverse groups, including recent immigrants from eastern Africa and victims of torture who are referred to us. All the details and subtleties of each unique cultural group cannot be learned quickly, but attitude and openness can be. The practitioners highlighted in *Minnesota Medicine* can be a model for all of us.

In my search for resources in the medical literature to use in teaching our residents, I have come across one important and helpful source that was not referenced in any of your articles. The *Western Journal of Medicine* has published two issues entirely devoted to cross-cultural medicine: December 1983 (vol. 139, no. 6) and September 1992 (vol. 157, no. 3). Both are available for purchase.

Hale N. Richards, M.D.
Internal Medicine Residency Program
Abbott Northwestern Hospital
Minneapolis, Minnesota

Patients Are Diverse; Truth Is Not

During the O.J. Simpson trial last year, it seemed painfully evident to me that a new paradigm of reason has pervaded our legal system. No longer are cases deliberated from a premise of truth (i.e., what actually happened), but they are now determined in therapeutic terms. What has preempted truth are matters of a more comparative quality: What effect will this verdict have on racial tension? What precedent will this decision set? How will this verdict affect a particular political movement or the culture at large? Matters of

truth, proof, evidence, even the very thought processes involved in discovering reality, seem to have been radically transformed and, perhaps, even lost in legal discourse.

As a physician who has spent more than two years working in Africa and Asia, I found your May *Minnesota Medicine* on cross-cultural medicine very interesting. However, I was discouraged that the trends of our legal system are quickly becoming the accepted and encouraged rationale of medicine. Whereas once treatment modalities were chosen on the basis of their proven benefits, which had been verified through quantitative methods, the empirical thought process is now being subtly pushed aside by reasoning of a more qualitative nature. Here are some quotes from your recent issue to illustrate this point:

"Most Minnesota physicians are proud products of the Western scientific method with a dogma about disease causation and therapeutic rationale that has little room for the use of a shaman or medicine man. We need to look for common concepts that allow us to bring our diverse patients the care we think they need, while acknowledging that we likely don't carry the only 'truth.'"

—Editor's Notebook by Charles Meyer, M.D.

"Culhane-Pera says she can accept a patient's rejection of a standard medical treatment for cultural reasons. 'What becomes hard,' she says, 'is when I feel the pressures of the external biomedical system to act in a certain

way. The conflict I feel is that I'm going to be criticized for not insisting that someone agree with the biomedical way. That's where the pain is. I don't want to be labeled as marginal, a quack, a bad doc.'"—Face to Face profile of Kathie Culhane-Pera, M.D.

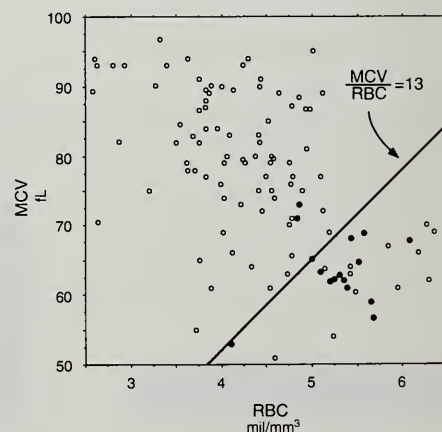
"The Western medical model can solve many problems, but there are limitations," observes [Marvin] Brooks, [M.D.]. 'I believe we're in the process today of a paradigm shift in the Western medical model, and one of the things that's going to push a re-examination of the model, in addition to economics, will be the change in the population—the change in who it is that we're dealing with and serving.'"

—Feature Story, "Strangers in a Strange Land."

I fear that my colleagues and I are being compelled to desert truth. We are inconspicuously being coerced to abandon Western medicine as we have known it and adopt a paradigm of reason very foreign to empiricism. This is not

Correction

The figure for the May Pearls & Pointers included an incorrect label. The following figure is correct.



Figure—Patients with (•) and without (○) beta thalassemia minor.

necessary even when interacting with foreign communities. In the two years I worked overseas, even though I adapted to and thoroughly enjoyed the cultures in which I was immersed, I never once felt compelled to leave that which I know is true. While it strained my mental faculties and tried my soul at times to respect the beliefs of the nationals and to attempt to understand their reasonings, I never reached the conclusion that I needed to adopt other systems of "truth" or a new paradigm of thought. It is one thing to respect the belief systems of our patients, but quite another to accept those belief systems as true and to actually work within them.

Unfortunately, there is no doubt in my mind that Dr. Brooks is right (see above). The new paradigm of thought to which he refers has become our culture. It has become our art. It has become our law. It is becoming our medicine. Medical science, in fact, is one of the few remaining bastions of rational thought in our culture to come under attack by the postmodern paradigm of relative truth. This paradigm does not esteem adherence to a model of empiric reasoning, but, rather, it esteems thinking that is flexible—"truth" that bends so much that it is unbreakable. In this thought process, empirical precision is no longer honored; truth, as we once knew it, has become tolerant of all other "truths." This model—of art, law, and medicine—is celebrated for its diversity. The problem is that we have begun to celebrate not the heritage of diversity in all its interest and beauty but, rather, to celebrate the diversity of truth. And diversity of truth is no truth at all.

*Charles B. Slater, M.D.
Spring Valley, Minnesota*

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Sports Medicine's Top Performers

Charles R. Meyer, M.D.

A century ago, the Journal of the American Medical Association soberly advised those taking up the new sport of bicycling to undergo a doctor's examination first, lest their hearts collapse under the strain ... (and) not "give way to the delirium of swiftness" ... and restrict their speed to no more than 7½ miles per hour.

—Item in the *Boston Globe*



"The elite athlete's machine is her body, and it's the sports physician's job to maintain and mend it."

Advise a maximum cycling speed of 7½ miles per hour—that was 19th century sports medicine. By 2096, much of our current exercise physiology and biomechanics advice may seem as misguided, but it won't be for lack of trying. Today, weekend and world-class athletes benefit from the sophisticated ministrations of medical specialties of all flavors. In Olympic 1996, medicine and sports are dancing ever closer, and this month's *Minnesota Medicine* looks at this *pas de deux* and considers the societal role of the sports partner.

Joe Moriarity shows us how medicine and sports collaborate to support the health of women athletes at the University of Minnesota (page 12), and Byron Crouse, M.D., shares his perspective from the medical tent at Grandma's Marathon (page 10). Our profile of U of M medical graduate and 1996 Olympic marathon trials winner Bob Kempainen describes another blending of medicine and sports (page 6). You'll find that sports medicine emerges as a multispecialty specialty treating the special needs of athletes.

Are athletes just another patient or are they something special? At the least, they have a different yardstick for measuring health and recovery. Try telling even the three-day-a-week jogger to lay off for a while to let a

joint rest. The more premier the athlete, the more precious is the performance. Unlike the Unsers, who can replace a blown engine, the elite athlete's machine is her body, and it's the sports physician's job to maintain and mend it. For sports physicians, that can mean finding a balance between the good of the patient and the goal of the game.

Usually, the balance is proper. But the pressure can be tremendous, as evidenced by past physician collusion with anabolic steroid use by high-performance athletes. Last month, the *New York Times* carried a story about David Cone, who pitched his last game for the Yankees after clinical evidence showed clots to his pitching hand and an angiogram revealed an aneurysm in one of his arm arteries. Whether his doctors and coaches crossed the threshold of good patient care is disputed in this well-written article, but Cone's case

does dramatize that doctors who treat athletes need to ask what's important for the patient, not for the game.

And how important is sports in our society? The shadowy side of this question is explored in Miriam Feldman's article on violence in youth sports (page 20) and in my review of the book "Lessons of the Locker Room: The Myth of School Sports" (page 51). With the primacy of winning, not only does medicine risk pushing sick athletes onto the field, but society risks distorting toughness into mayhem and determination into anger.

Garrison Keillor once said that the gift of athletics is "to teach us loyalty as a powerful emotion and to learn chauvinism when we're small so that we can grow beyond it as we get older. It's important," he said, "to learn loyalty and to be a part of a team." Unfortunately, many adult spectators and athletes have not lost their childish chauvinism. Individuals have eclipsed the group, and with the sanctification of superstars and self, the solo end-zone celebration has replaced the team hurrah.

But all is not shadows. Athletics is a healthy, almost poetic part of our medical and societal life. It can foster courage, teach cooperation, and build confidence. It entertains millions. It galvanizes stadium thousands, towns, and countries. Who doesn't remember without goose bumps the 1980 U.S. Olympic hockey victory or the triumph of the 1987 and '91 Twins?

Medicine and sports can be graceful partners. Athletes and the medicine that keeps them operating at top condition advance together. Whether the performer is a world-class athlete or weekend warrior, sports has much to teach—not about anger and chauvinism, but about tenacity and loyalty.

MM

PHOTOGRAPH BY TIM DE FRISCO



World-class marathoner and University of Minnesota medical graduate Bob Kempainen has covered a lot of ground training for the 1996 Olympics and for his life as a physician.

GOING *the* DISTANCE

BY DOUGLAS CLEMENT

It's about 2 p.m. on April 15 in Boston, Massachusetts, and more than 38,000 long-distance runners are nearing the finish line of the Boston Marathon. As the lead runners climb the crest of Boston's notorious Heartbreak Hill, Bob Kempainen, the American record-holder for the Boston Marathon, pumps hard, breathes easy, and stares straight ahead. But Kempainen isn't in Boston.

He's in the living room of his south Minneapolis home, watching live TV coverage of the marathon, and his Nike-clad feet are pumping air in a sympathetic twitch with the runners. Kempainen is sitting out today's race because he's training for an even greater competition: the 1996 Summer Olympics.

Kempainen is America's top marathoner, winner of the February 1996 U.S. trials at Charlotte, North Carolina (despite repeated vomiting during the last two miles), and record-setter for the fastest marathon by an American with his blistering 2:08:47 at the 1994 Boston Marathon.

On August 4, Kempainen will be one of three Americans in a field of about 150 Olympians racing for gold over 26.2 hot, humid Georgia miles. And while it seems sensible for Kempainen to skip the Boston Marathon this year to train for the August race, there is another reason: he had just completed his final day of medical school on April 12.

Over the last six years, Kempainen has led a dual life: world-class marathoner and successful medical student. The University of Minnesota Medical School allowed him to stretch out his course of studies to accommodate his training and competition. And Kempainen, a laconic 30-year-old who speaks modestly of his accomplishments, notes that he couldn't have done it otherwise. "I've taken six years to get my four-year program done, and I don't think I would have run well if I hadn't taken the two extra years," he says as he carbo-loads on a bagel and cookie from the nearby Bruegger's. "It would be slighting medical students in general to somehow imply that I was able to run well and take a full schedule."

Those who know Kempainen note his capacity for keeping these roles separate. "Very few of the people he's worked with [in medicine] have even understood that he has another part of his life," says Scott Davies, M.D., head of pulmonary and critical care at Hennepin County Medical Center (HCMC) and Kempainen's adviser at the University of Minnesota. "He's very low-key, humble, and down-to-earth. Doesn't strike you as a world-class athlete. Quite a remarkable fellow."

Kempainen is a local hero, born and raised in Minnetonka, where he followed his older brothers, Todd and Steve, into athletics. (Todd was an alternate on the 1980 U.S. Olympic cross-country ski team. Steve won the Minnesota high school two-mile track title.) Bob started running the mile in junior high and moved to the two-mile at Hopkins High School, winning the state two-mile championship in 1984. In college, he moved to 5Ks and 10Ks.

"It just seemed like the longer the race, the better I did, so I wanted to run a marathon," says Kempainen. In October 1991, he ran his first: the Twin Cities Marathon, from the Metrodome to the state Capitol, and finished just two seconds behind the winner. In April 1992, he qualified for the Olympics by finishing third in the U.S. trials, despite a stress fracture in his right knee and tendinitis in the other. And in August 1992, he finished 17th at the Barcelona Olympics. Excellent finishes in New York, Boston, Los Angeles, and Charlotte, North Carolina, marathons in the last four years have further established his credentials as America's hope in Atlanta.

Still, there is more to life than running, and Kempainen is the first to say so. A 1988 Phi Beta Kappa Dartmouth graduate in biochemistry, Kempainen took two years off to train before beginning medical school, and during those years assisted with several research projects at Dartmouth and Chapel Hill. He soon realized that the research pay-off was too delayed for him. "Research is essential to any long-term strides in medicine, but it takes place over such a long time—you could put 10 years into something before you see even the smallest gain."

In clinical medicine, on the other hand, the rewards are "more immediately gratifying," he says, and the human aspects of medicine are important. "I like dealing with people, like dealing with patients, talking to them, getting to know them and what seems to work for them."

It's a side of Kempainen that HCMC's Davies appreciates. "He's a patient-centered doctor, very interested in patients and their families, what they're about, and the social aspects of their care."

Kempainen's social concerns extend beyond medicine. When he takes time off from medical school to train, he often volunteers with community organizations, sorting canned goods at a food distribution center in Colorado, for instance, or collecting data for a study at a poison control center in San Francisco.

Kempainen winces when he recalls a 1994 *Runner's World* article that mentions a job he took as a nursing home attendant. "That [reporter] was talking up some Mother Theresa side of me. It's not as impressive as they like to make it out to be," says Kempainen, who quit the job after just two weeks when he discovered his stress fracture.

Nonetheless, he admits to a social conscience. Because he's had great opportunities in life, he feels volunteering provides a chance to give something back. Moreover, volunteering prevents the narrow self-absorption that some athletes suffer. "When I'm just training, there's

time on my hands, and volunteering offers interaction with others. You're not just totally focused on yourself. For me, this is probably more healthy mentally."

Kempainen says the same about medicine—that it has provided an important mental ballast to his running, though it has undoubtedly competed for time and energy. Long hospital rotations tire his legs and slow his running. Races are often wedged into intense work schedules. In November 1993, for example, Kempainen left his HCMC neurology rotation late on a Thursday afternoon, flew to New York, raced a Sunday marathon, came in second, then flew back to Minneapolis for a Monday morning hospital shift.

"It may have hurt me a little bit; I'll never know," he remarks of the competition between running and medicine. "If I'd focused on training all this time, maybe I'd be running faster. But my sense is I wouldn't be happy, so I guess that's the bottom line."

This fall Kempainen begins his three-year residency in internal medicine at HCMC. He spent the early spring running through the Rockies near Fort Collins, Colo-

rado, in preparation for Atlanta. What are his chances of winning the Olympic marathon, a feat not accomplished by an American since Frank Shorter in 1972? "I'll do all the things I can and run as hard as I can," says Kempainen, with Minnesota understatement. "Whatever place I get is what happens."

MM

Doug Clement is a free-lance writer in Minneapolis.

Editor's Note: As Minnesota Medicine goes to press, Kempainen is suffering from tendinitis of the iliotibial band and hamstring strain, which is restricting his Olympic preparation to working out on a ski machine, stretching, receiving ultrasound treatments, and resting his legs. He has been unable to run his normal 100-plus miles a week in training for the Olympic marathon August 4.

Kempainen has until July 15 to decide whether he's able to run in the Olympics. If he can't, the fourth-place finisher at the trials, new University of Minnesota cross-country coach Steve Plasencia will be invited to compete.

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MARATHON DAY

A View from the Medical Tent

By Byron J. Crouse, M.D.

As I walk down Duluth's Canal Street, the sun appears over Lake Superior. The streets are unusually quiet on this cool June morning. At the finish area to Grandma's Marathon, the street crew efficiently puts up crowd barriers and erects scaffolding to support the timing clock, but the medical tent is empty. This calm is short-lived, however. The tent comes alive as the first of several hundred volunteers arrive to set up the cots and arrange the tables and supplies. A sense of anticipation fills the air.

The Gary Bjorkland Half Marathon starts at 6:30 a.m. Fifteen minutes before the start, the final temperature measurements from along the course are radioed to the medical tent to determine the thermal risk score and select the appropriate race flag for alerting the runners. The National Weather Bureau is contacted to verify that no thunderstorms or severe weather is approaching. The Grandma's



For a marathon medical team, winning isn't about crossing the finish line; it's about preventing injury and providing quality care for all runners.

Marathon board chair, the race director, and I, the medical director, confirm that all is safe to begin the race, and the runners are off. In a little over an hour, the first of the runners will cross the finish line.

Final preparations are made to carry out plans begun in January. The volunteers—physicians, nurses, physical therapists, EMTs, students, radio operators, and computer staff—are given their final instructions, and they stream toward the finish area to cheer on the first runners. Usually, the half-marathon runners have fewer and less intense medical needs, so many of the volunteers are scheduled

to work in the tent later, when the runners from the full marathon will need aid.

Unexpectedly, we receive a radio message that a runner in the half marathon has collapsed just short of the finish line. A team from the medical tent is sent to meet the finish line team, which is bringing the runner to the tent. We find the runner's name and age on the computerized registry of runners' bib numbers. He is a 17-year-old with no other medical history noted. The young man is hot and dry to the touch, hypotensive, and unresponsive. His rectal temperature is measured, but the mercury thermometer can't be read and is reportedly "broken." A second thermometer is obtained, and someone informs me that this one, too, is broken. I check the thermometer myself and realize it is not broken; the runner's temperature is over 107°F, the mercury topping off the scale.

The runner is diagnosed with heat stroke. We begin intravenous fluids and cooling with ice and fanning, which lowers his core temperature to 101°F. Several of his friends come by to see how he is. We learn that he runs on a local track team, but he never runs more than five miles and is usually the slowest of the group. Today he was out to beat his friends, running faster and farther than ever before. His friends also report that he had not been stopping to take water at the water stations. He pushed himself to the point of overexertion, which was complicated by dehydration and finally hyperthermia. After several liters of fluids, his blood pressure is still low. We transfer him to a local emergency room, where his blood pressure improves with additional fluids, and he is subsequently sent home. Later follow-up revealed no further sequelae from this episode.

Fortunately, this runner had a good recovery. He learned the importance of running within his level of conditioning, and more important, about staying hydrated while exercising. Those of us working in the medical tent were reminded that we need to be prepared for any situation, even with the shorter race.

The Grandma's Marathon runners are now crossing the finish line. One runner arrives in the medical tent assisted by several fellow runners. This 67-year-old man has just completed his seventh marathon. Although he took fluids at each water station, he tells us that he took less fluid than usual because the day is cool. After finishing the race, he began having muscle spasms. First the spasms were

mild and confined to his calf, but now they are more severe, involving both legs and making him unable to walk. His blood pressure is low, but he is able to take oral fluids. His muscle spasms continue to intensify. We begin intravenous fluids to replenish his vascular volume more quickly, and physical therapists begin muscle massage and stretching. His spasms later subside, but not until he has gone through periods of whole body tetani. The spasms let up momentarily, only to begin again in another muscle and spread like a wave to grip his whole body. All he can say is, "Why now? I've never had trouble like this in my previous six marathons?" Usually followed by, "I'm never going to run another marathon."

Throughout the day, many runners set their personal record times, and a number of them require medical attention. Like every year, we treat foot injury involving blisters or nail trauma. It amazes me that runners purchase a new pair of shoes, put them on, and proceed to run 26 miles without breaking in the new shoes. Also common is dehydration, with its accompanying symptoms of muscle cramps, weakness, and lightheadedness. Less frequently, we see problems like runners' colitis, asthma, or hematuria.

Seven hours and 400 patients later, the day has ended. The equipment is packed and stored for next year's race. I walk back down Canal Drive almost 12 hours after my arrival. The streets are tranquil again except for a few spectators making their way back to their cars. I'm surprised at how fast the crews take down the crowd barriers and return the streets to normal. But the quiet is not complete; in the distance, I hear the sounds of celebration. MM

Byron Crouse is an associate professor and head of the Department of Family Medicine at the University of Minnesota-Duluth School of Medicine. He has been medical director of Grandma's Marathon for five years.



PHOTOS BY JEFF FREY & ASSOCIATES PHOTOGRAPHY



*Sarah Pearman,
University of Minnesota
volleyball team. Photo by
Gerry Vuchetich, U of M
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A CADRE OF HEALTH CARE PROFESSIONALS—PHYSICIANS, ATHLETIC TRAINERS, NUTRITIONISTS, AND SPORTS PSYCHOLOGISTS AMONG THEM—WORKS TOGETHER TO KEEP THE UNIVERSITY OF MINNESOTA WOMEN ATHLETES HEALTHY AND INJURY-FREE.

TEAM SPIRIT

BY JOSEPH M. MORIARTY

Volleyball. Sarah Pearman began with a nerf volleyball in third grade, and she's lived and breathed the sport ever since she began playing competitively as a seventh-grader in the Apple Valley school district. Though she's only 5-foot-9, Pearman's leaping ability made her a well-recruited front-row player during her senior year in high school. "I really wanted to play Division I volleyball in college," she says, "and when the University of Minnesota offered me a four-year scholarship, I was elated."

Pearman had barely begun her college career when a small patch of sweat on the court brought her volleyball ride to a halt. "In a preseason game my freshman year, I came down from a hit, slipped, and went down," says Pearman. "I felt a sharp, momentary pain in my knee, and then numbness, but I really didn't think I'd done anything more than sprain it."

The team's athletic trainers were not so optimistic. They immobilized the knee, and after talking to Elizabeth Arendt, M.D., an orthopedic surgeon and medical director of the university's varsity athletics, they suggested Pearman have an MRI done as soon as possible. "The next day," she says, "I got the bad news from Dr. Arendt: a torn anterior cruciate ligament."

Pearman's injury and recovery brought into action the health care team behind the U of M athletes—a team of professionals who focus on injury rehabilitation and prevention. That an athletic trainer was the first person to see and triage Pearman's injury is not unusual.

At the University of Minnesota, athletic trainers are the athlete's main contact with the sports medicine team. "Every school has its own model for providing athletes with care, but here, athletic trainers organize all the resources for our student athletes," says Sally Mays, head athletic trainer for Women's Intercollegiate Athletics, director of student development, and an instructor in the Department of Kinesiology. "The team also includes nutritionists, family practitioners and specialists, physical therapists, massage therapists, and mental health counselors. Our main function is to provide day-to-day continuity for our athletes' care and treatment."

It's a system available only to the athletes, according to David Wang, M.D., women's athletics team physician, a family practice professor at the university, and a former "often-injured" college athlete. "If [other people] get hurt, they go to their family doctor. Here, the athletes have a whole system set up to

accommodate them—one that includes a team of professionals who are very accessible.”

As Mays explains, “The athletic trainers and the doctors communicate daily. Dr. Arendt has asked us to keep her up-to-date on the status of all players who are injured. We take care of the rehabilitation, and if more physician care is needed, the appropriate doctor will be pulled in to help.”

“To say that the athletic trainer is the main person

triaging injuries is not an inaccurate statement,” explains Arendt, “but neither do they function like a family practitioner. They do, however, have day-to-day contact with these athletes, and, consequently, know them best. As such, they clearly are the physician’s eyes and ears.”

For acute injuries like Pearman’s, Wang, Arendt, or another physician will be involved. “For common and less serious injuries, the athletic trainer will ini-

On the Road to Atlanta

Reaching the Olympic Games demands hard work and top skills for the medical team behind the athletes.

Participating in the Olympic Games is a tremendous honor for any athlete. And it’s equally exciting for those behind the scenes who support the athletes—people like Sally Mays, who was recently chosen as a member of the official United States Olympic Committee (USOC) medical staff. Mays, who is head athletic trainer for the University of Minnesota Department of Intercollegiate Women’s Athletics, director of student development, and an instructor in the university’s Department of Kinesiology, joins a medical team composed of 31 athletic trainers, 12 physicians, and one chiropractor.

The predominance of athletic trainers on the USOC medical staff illustrates the important role these allied health professionals play in athletics and reflects the degree of training and expertise they have in sports medicine. These men and women—drawn from among 15,000 board-certified athletic trainers throughout the country—will work to keep the Olympic athletes healthy. To do so, they will develop and use quick rehabilitation methods for injuries and make sure all possible preventive measures are in place.

“Athletic training was rec-

ognized as an allied health profession in 1990,” says Mays. “While there are some bachelor-level programs in athletic training, most people enter the field through an internship program while getting a B.A. in a related area, such as kinesiology or exercise physiology, with athletic training as a minor. The next step to certification is a minimum of two years of experience (1,500 to 2,000 hours) working under the direct supervision of a certified athletic trainer. Only then is one eligible to take the board of certification exam.”

In reality, to get a job today, athletic trainers need education and experience beyond the B.A. level. Most athletic trainers have a master’s degree in athletic training or a related field, such as sports medicine, kinesiology, exercise physiology, or biomechanics. Mays, who holds a B.A. in education and athletic training, completed her master’s degree in sports medicine at the University of North Carolina–Chapel Hill and is also a certified strength conditioning coach and massage therapist.

In addition to her responsibilities in the athletic department, Mays, who has worked at Division I universities since



Sally Mays, athletic trainer

tiate the first line of treatment based on set protocols," says Arendt. "If the athlete's injury is unresponsive to treatment, then we'll usually be contacted to see if there's something more we can suggest be done."

"Athletic trainers are an excellent adjunct to the physician," continues Arendt. "They are very skilled at understanding and diagnosing acute injury, and they really know how to bring people back from injuries. Other fields of medicine aren't always as

good at these two things."

Collegiate sports medicine is a complex system that relies on trust and excellent communication—and one that Wang, Arendt, Mays, and others on the health care team believe works well for them and the athletes.

After successful surgery, Pearman began her long, demanding rehabilitation regimen. "Just a week after surgery, I was already seeing the athletic trainers and

1989, also teaches athletic training courses in the university's Department of Kinesiology.

"The undergraduate program in kinesiology prepares individuals for roles in sports and health clubs or corporate fitness and exercise centers," explains Mays. "It serves as a background for initial licensure in masters of education programs in physical education, exercise rehabilitation, exercise physiology, biomechanics, social psychology of sports, motor behavior, and ergonomics. Programs for coaching licensure, junior and senior high school health and physical education, and for working with special populations are also housed in this department."

For an athletic trainer, reaching the Olympics is the culmination of a great deal of work, a high level of competence—and a bit of good luck. The road to the Olympics begins five years after graduation, when athletic trainers become eligible to apply for a voluntary rotation in the USOC's sports medicine program.

"If they call," says Mays, "you'll first be asked to volunteer for two weeks at one of the three USOC training centers—in Colorado Springs, where I went two summers ago, Lake Placid, or San Diego."

After the athletic trainers complete their initial two-week tour, the full-time medical staff evaluates their performance as well as their ability to work as part of a team and handle new and diverse situations. Those who make it past this screening are invited to work at a U.S. Olympic Festival or Pan-American Game. Mays returned to work at last summer's Olympic Festival in Denver, where she was assigned to the U.S. men's and women's basketball teams.

"Our role there included providing medical care to our team during competition, as well as helping staff the clinic for all athletes, coaches, and administrators when our team was not involved in practice

or games," says Mays. "The hours were often long; it's not unusual to begin at 6 a.m. and go until the last athlete has been treated—often 9 or 10 p.m. or even later."

Those athletic trainers who pass another round of evaluations can then be asked to participate in the Pan-American or World Games, and finally, the Olympics.

Mays skipped a step when she was asked to come to this year's Olympics in Atlanta, Georgia, to work with the U.S. women's volleyball team. "My tasks will be similar to those I have here at the university," she says. "That means being responsible for the volleyball team's care during the time they're at the Games."

The USOC medical team works like this: an athletic trainer will do the initial evaluation of an injury; the physicians—orthopedists and family practitioners—make the diagnosis and then, basically, let athletic trainers carry out needed treatment and rehabilitation, says Mays. The family practice physicians and chiropractor generally treat anyone who needs their care, while the orthopedists are assigned to specific teams and sports—predominantly the ones with a higher incidence of injury, such as boxing, wrestling, volleyball, soccer, and basketball.

Besides the personal thrill of participating in the Olympics, Mays finds that the USOC athletic training volunteer program offers practical experience she can bring back to Minnesota. "Every time I've returned from a stint with the USOC, I've changed or added something in our training facility here at the university based on what I've learned. Working with elite athletes and some of the best athletic trainers in the country helps me tremendously in my job," she says. "It's the best continuing education I could ever receive."

—JMM

a physical therapist at the university's orthopedic center," says Pearman. "Four or five weeks later, I was spending three to four hours a day in rehab, including time with physical therapists, strength and conditioning coaches, and athletic trainers."

An injury like Pearman's can also be psychologically devastating when sports is an all-consuming passion. "Division I athletes are college athletics' elite, and often their identity is very wrapped up in being an athlete," says Shelly Shaffer, sports psychology consultant for women's athletics. "When an injury strikes, a lot of questions come up. Will they get their position back? Will they even be able to play again? What would life be without athletics?"

The ACL tear was Pearman's first injury, and adding to her dismay, her teammates left for a major tournament in Arizona the day after her fall. "Here I was facing surgery and half a year of rehabilitation before I'd even know if I could play again. Aside from

volleyball, I'm a pretty active person, and, suddenly, there was a lot I couldn't do. It was really hard to hit a wall like that," says Pearman.

One of the athletic trainers suggested she talk to the department's sports psychologist at that time, who helped give her a new outlook. "I learned about going on with my life and focusing on the things I could control. Looking back now, the injury really did help me put my life, my education, and athletics in perspective. The injury gave me a chance to concentrate on school, and I see now how important that is. Volleyball is not my whole life anymore. My education, not volleyball, is my future."

Sports psychologists like Shaffer also work with physically and mentally healthy athletes who are simply trying to optimize their performance. "Not long ago, I saw a track athlete who was so anxious before her races that she'd vomit," Shaffer says. "I taught her some relaxation techniques, explained how to use

positive self-talk and set goals—and now she's doing fine. I also work with teams on cohesion issues, building confidence and motivation, and preparing for competition."

Optimal performance also depends on good nutrition. "We have a nutritionist talk to all our athletes about their eating habits and need for calories," says Lisa Buck, a nutritionist with Boynton Health Service and consultant for women's athletics. "We're trying to help them find the correct balance to stay healthy. We're also trying to help our athletes stay away from body image concerns. Eating disorders can occasionally be a problem, too, so we watch for this."

The real emphasis of the sports medicine



David Wang, M.D., University of Minnesota women's athletics team physician, is prepared to help athletes both on the field and off.

program, however, is injury prevention. "While some sports injuries are unavoidable," says Mays, "much can be done to minimize their occurrence through an aggressive prevention program." Mays' department begins each school year with a comprehensive screening and evaluation of each athlete to identify risk areas and problems. "We then put them on an individualized conditioning and flexibility training program that is very intense for the first few weeks," Mays explains. "Then they're put on a maintenance program. Our goal is to fix the little problems before they become big problems."

Of course, no program can prevent injury altogether, and every injury is given the needed attention. "We consider every injury serious at this level if it results in time lost from either practice or competition," says Mays. "It's as simple as that—though some injuries result in more time away from practice and competition than others and require much longer recovery and rehabilitation."

"There hardly ever seems to be a time when a whole team is injury-free," Mays continues. "Injuries run in streaks, too. One year, a team may have very few injuries, and the next year, nearly everyone gets hurt."

According to Mays, contact or collision sports, like hockey, volleyball, basketball, and football, generate the majority of trauma injuries, such as acute ankle sprains, knee sprains, and ACL tears. On the other hand, non-contact sports—swimming, tennis, cross country, track and field—bring on injuries caused by overuse, such as stress fractures and tendinitis.

"It's in the latter category that good conditioning and strength training can really help," says Mays. "We identify and work on the risk areas inherent in a particular sport. For example, when I came to the university two years ago, the softball team had a history of shoulder problems. Once we got [the players] on a program for rotator cuff strengthening—which they hadn't been doing—the problems pretty much disappeared."

Strength training and conditioning continue for these athletes even during injury rehabilitation. During her absence from volleyball, Pearman's program involved overall strength training and swimming, as well as exercises specifically designed to strengthen her leg and knee.

By the following spring, her work was finally paying off. "I was just bouncing off the walls because I wanted back on the court so badly," says Pearman.

The decision to return to competition after an injury is made not by the athlete or coach, but by the medical team. According to Mays, the push by schools to keep injured athletes playing and to rush their return to competition after an injury is different at every school.

"At this university, the athletic director, the athletic department, and the coaches recognize that the decision to play is ours [the medical team's]—and I believe that's how it should be," says Mays. "We

"We won't play someone at the expense of their health. I won't say that the coaches always like our decisions, of course, but they support them. Our student athletes sometimes press us to let them play, too, but when they do, we know they're not taking the long view."

—SALLY MAYS

won't play someone at the expense of their health. I won't say that the coaches always like our decisions, of course, but they support them. Our student athletes sometimes press us to let them play, too, but when they do, we know they're not taking the long view."

"Our goal is to have athletes who leave here with a degree, *and* with the ability to go out and play Frisbee with their kids when they're 35 or 40," says Mays. "What we do now, we do for life—not for the next game."

Pearman discovered, however, that though physically she was more than ready to play, mental barriers remained. "It's not at all unusual for athletes to have a strong fear of re-injury," says Mays. "Sarah was leery of jumping and coming down from a hit and diving on the injured leg. And once everyone in a game or practice started sweating, she'd be pretty paranoid about slipping on the floor." To work through her fears, Pearman again spent some time with the sports psychologist. "It took a while, but [the psychologist] really helped me get through all that," Pearman says.

Supervised and coached by a highly trained and experienced team of professionals with myriad resources at their fingertips, these Division I athletes are able to avoid many minor injuries and optimize recovery time after the more serious ones. Wang says that taking care of and understanding the whole person is important in sports medicine, just as it is in primary care. He considers his work with these student ath-

letes to be primary care for a special population, and he applauds the athletic department's team approach.

"I run a sports medicine clinic in my regular practice," Wang says, "and I refer to other practitioners, such as physical therapists or chiropractors, whenever it's appropriate. I've studied acupuncture some, and spent time learning manipulative procedures with an osteopath. I did this not to practice these techniques, but to better understand what these practitioners do and what they have to offer my patients. Ultimately, to do the best job we can, not just in sports medicine but in medicine in general, we need to learn whatever we can from all who have something to

offer—and keep an open mind and use what works, even if it's not something we learned in medical school."

The results Pearman achieved were gratifying to those involved in her care and rehabilitation—not to mention Pearman, herself. "Today," she says, "my knee feels good, and the injured leg is actually the strongest of the two now. I was really nervous about getting my jump back."

She needn't have worried; her jump is an inch higher than before the injury. MM

Joseph Moriarity is a free-lance writer living in Marine on St. Croix.



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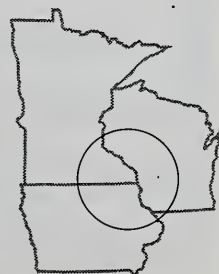
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POWER PLAY



PHOTOGRAPH BY BILL ALKOTER/PIONEER PRESS

In youth sports, as in the big leagues, the true meaning of competition has lost out to winning at any cost—too often with violent results.

By Miriam K. Feldman

Winning isn't everything," the legendary Vince Lombardi used to say. "It's the only thing."

Call it the trickle-down theory, if you will, because that attitude has made its way from the Green Bay Packers all the way down to pee-wee sports. "Marking" players for deliberate injury, name calling, trash talking, taunting, grabbing or shaking players in a fit of anger, cursing at young athletes—it's all part of the game. Welcome to the world of youth sports.

Any number of theories are used to explain the growing level of violence on the kids' playing field. One is that sports reflects

the violence in society, including the increasing violence among sports superstars, both on the field and off. Poverty, family breakdown, and the influence of the media are also offered as possible explanations for the erosion of civility on the playing field. Another theory is that sports has become serious business—at every level. All eyes are on the prize, perhaps a sports scholarship or even a professional team contract. Whatever the reason, youth sports isn't just for fun anymore. In fact, it can be downright dangerous.

Increasingly, competition involves mental or physical harassment of players. "In some cases, kids are encouraged to injure other athletes, go for their weak knee—physically overcome them or go for their vulnerability," says Cordelia Anderson, who has written three publications on the topic of youth sports and child abuse, including a booklet for the Minnesota Children's Trust Fund called "Keeping Youth Sports Safe and Fun."

But Anderson believes the situation can improve. "Violence has been dealt with in the military, schools, family, and the faith community," she says. Now it's being looked at in youth sports, where it runs along a continuum from rowdy crowd behavior, to verbal taunting, to deliberate bodily harm.

Lyle Helke, who recently has been involved in developing codes of conduct to encourage respectful behavior among athletes and coaches at schools in White Bear Lake and others in their conference, believes that our overall tolerance of violence has carried over to the playing field. Times have changed, observes Helke, who has been coaching cross-country running and track for the past 21 years and is health educator and chemical health coordinator for White Bear Lake schools. "Power and control are becoming more and more the issues that drive people to whatever they're after." The person with the most material goods is declared the winner.

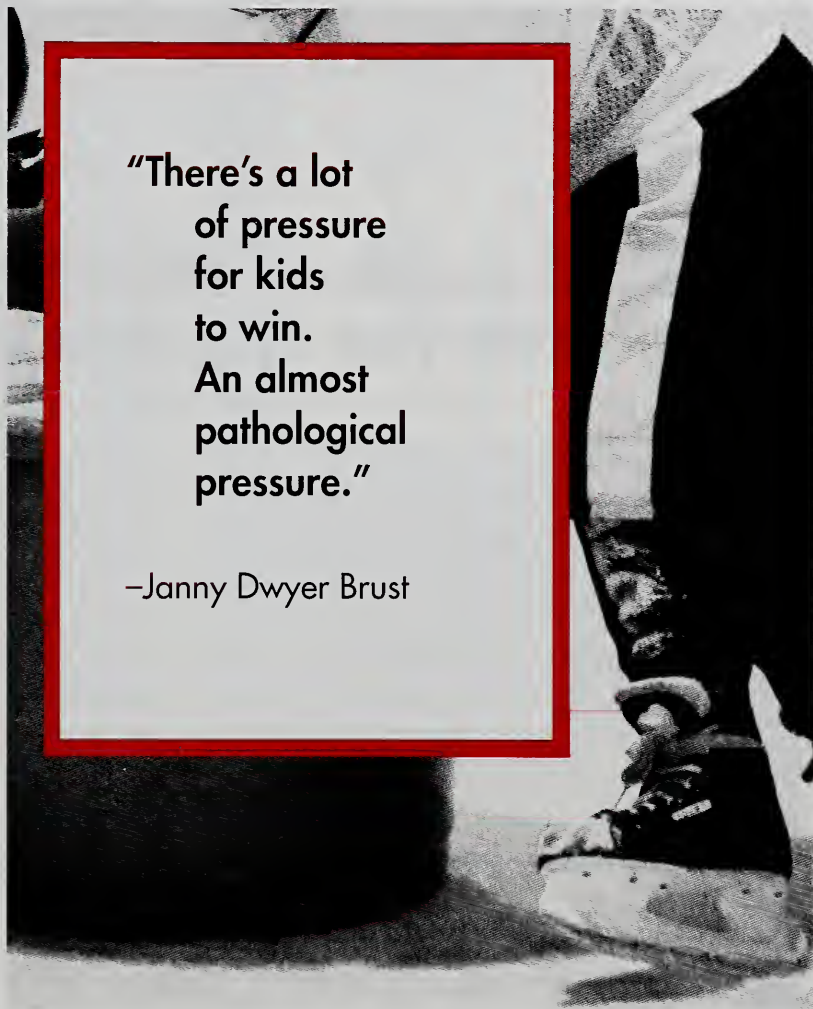
As Anderson sees it, the problem boils down to one word: Attitude. We've forgotten that youth sports is about having fun, she says. "They [kids] don't want to be screamed at, sworn at. They don't want to be told, 'You're a stupid idiot,' by a coach and a parent."

But all too often, they are. What's more, kids are being physically injured when rules aren't enforced.

Some coaches look the other way when players deliberately try to take someone out of the game. In hockey, they do that through illegal checking or collision with

**"There's a lot
of pressure
for kids
to win.
An almost
pathological
pressure."**

—Janny Dwyer Brust



PHOTOGRAPH BY PAUL DOIS

another player. In football, they do it by "marking" another player for injury. Helke calls this "sanctioned violence." Anderson says: "If you did that on the street, it would be an assault."

Janny Dwyer Brust learned about avoidable sports injuries when her son was injured during an ice hockey game. I had a "bleeding, screaming, crying child for something that absolutely didn't have to happen," says Brust, who is director of population-based initiatives at the Allina Foundation. "It was a 100 percent preventable injury that occurred because safety-first issues were ignored."

That incident prompted Brust to study youth ice hockey injuries, and with the collaboration of several colleagues, she discovered that such injuries are on the rise, in part because of the ruthless attitude of players,

parents, coaches, and fans. Her study cites Canadian research that found a significant rise in youth ice hockey injuries in a 20-year period. From 1966 to 1979, fewer than one catastrophic spinal cord injury per year occurred in one Canadian region; from 1982 to 1986, the number had risen to 13 per year.

"There's a lot of pressure for kids to win. An almost pathological pressure for them to win," Brust says, adding that when that happens, kids will do almost anything, including deliberately harming other players.

We've forgotten the true meaning of competition, says Anderson, whose most recent book, "The Sport in Me," teaches children and parents what it means to be a good sport. "The old value was how it [sports] helped prepare you for life—not how it *was* your life," she says. "It was one of the great places for youth to learn manners, civility, and lessons in winning and losing."

Not anymore—not since the ante was raised. Now, children as young as 6 or 7 are being pushed onto a professional track, forced to focus on one or

STOP THE VIOLENCE

What Can Physicians Do?

In response to the growing level of violence throughout society, the Minnesota Medical Association started its Stop the Violence Campaign in 1992. What began as an effort to end domestic violence and abuse has expanded to include efforts to stop the media violence and to reduce youth access to firearms. The MMA has published tips to help physicians counsel patients in each of these areas. For more information, or to order brochures, contact Beth Hoheisel at the MMA, 612/378-1875 or 800/999-1875.

Youth violence on the playing field is just one more aspect of society's increasing violence. Physicians may believe such violence is out of their realm, but they can be part of the effort to put the fun back into youth sports. As a start, they can carefully document sports injuries by stating in the medical record whether the injury was intentional, unintentional, or unknown, says Janny Dwyer Brust, director of population-based initiatives at Allina Foundation. "There's no way to know the magnitude of the problem without documentation," she says.

Physicians also can report injuries to the appropriate sports associations or school leagues. And finally, they can take a stand in their communities. "They have a lot of influence and expertise," says Brust, who has studied youth ice hockey injuries. "Physicians need to advocate for fair play. They can stand up for kids' safety."

—MKF

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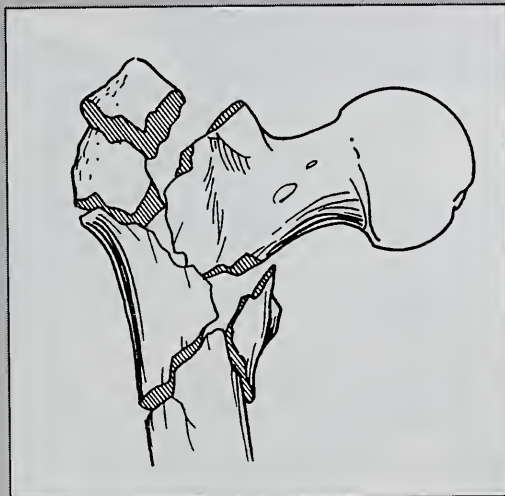
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PHOTOGRAPH BY PAUL DOIS

two sports, which they play year-round, including summers at specialized sports camps. When the focus is so narrow and intense, sports loses some of its recreational quality, Brust argues. "This kid's identity is wrapped up in being this person who can do hockey or soccer. People see scholarships or professional careers at the end of that rainbow."

Helke agrees, recalling that kids used to be encouraged to explore different sports. "Now the message is, 'You're going to play hockey year-round.'

up to are going in a different direction."

Brust agrees that change is slow. "Moving from awareness to behavior change requires a lot of steps in between," she says.

As Anderson puts it: "The message is to keep children first. We want to interest children in fitness for life. We want to help them reap the benefits of being involved in sports."

MM

Miriam Feldman is a free-lance writer in Minneapolis.

When you invest that much in one thing, after a while you're going to protect it."

Still, Anderson sees "a tremendous amount of hope" that the situation can be remedied. "There are a lot of people saying, 'Wait a minute. This does not seem right.'"

That's been happening in Ramsey County, where coaches, players, and parents now sign a code of conduct before playing in area ice arenas. Getting participants to pledge responsible and respectful behavior is an outgrowth of the county's initiative to reduce violence in the workplace, says Greg Mack, director of parks and recreation for Ramsey County. County employees had learned through their nonviolent work policy that they had a right to control the behavior occurring at the ice arenas. So they developed a code of conduct to end the growing problem of vandalism in the locker rooms and the belligerent behavior of players, coaches, and fans.

Mack has noticed an improvement since last fall, when the contracts were first put to use. Now, when coaches come to the arena, they must sign in as a responsible party. It boils down to a matter of respect, he says. "Respect for other people, other people's property, their common property."

The Ramsey County initiative may be proof that greater attention is being paid to violence in youth sports. Still, challenges lie ahead. Helke, who speaks of "baby steps" toward progress, says, "I don't think we're going to get there overnight." Outside influences make the job even harder, he adds. "What's happening in society is contrary to that movement. The role models kids look

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3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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Noncemented Femoral Components in Total Hip Arthroplasty for Patients with Rheumatoid Arthritis

Kevin R. Walker, M.D., Richard F. Kyle, M.D., and Ramon B. Gustilo, M.D.

ABSTRACT

Twenty-seven patients with rheumatoid arthritis underwent cementless total hip arthroplasty from 1982 through 1989. We performed all operations through a posterior approach. Postoperatively, patient convalescence consisted of ambulation with crutches, followed by weight bearing as tolerated until pain and discomfort subsided. We contacted 25 (92.5%) patients for follow-up. Combined, these patients received 34 total hip arthroplasties. The patients ranged in age from 14 to 69 years old with a mean age of 42.9 years. The follow-up period ranged from two to eight years with a mean of five and one-half years. The mean preoperative total Harris hip score was 48 (range 31-68). The mean total Harris hip score at latest follow-up was 80 (range 44-95). Hip pain status and functional ability were important indicators of treatment efficacy. The lower incidence of pain, as well as the increase in functional abilities experienced by the patients, suggests that cementless total hip arthroplasty is a preferable alternative to fixed arthroplasty in patients with rheumatoid arthritis.

Hip involvement is an important cause of disability in rheumatoid arthritis patients,¹ and total hip replacement is a suitable treatment for individuals with severe hip involvement. However, the disease process in rheumatoid patients introduces several factors that may affect outcome. First, because of significant bone resorption and osteopenia, rheumatoid patients' overall quality of bone stock is diminished. Second, patients with rheumatoid arthritis are frequently younger than those with osteoarthritis; thus, the longevity demanded of the arthroplasty may be greater. Third, the systemic and multi-articular character of rheumatoid arthritis diminishes the activity levels of these patients, resulting in diminished physical load exerted on the prosthesis. The extent to which any or all of these considerations may affect outcome is, as yet, unclear.¹

Several authors have reported results of cemented total hip arthroplasty (THA) in rheumatoid patients. Unger et al. report a revision rate of 16.7% and a satisfactory outcome in 80.7% of those patients not requiring revision.² Poss et al. report a revision rate of 1.6% with 96% of their patients considered "clinically improved."³ Also, Unger reports that hips were more likely to fail secondary to loosening of acetabular components. On the other hand, all of Poss' revisions were of the femoral component. In addition, Severt et al. report a revision rate of 7% with significant improvement in pain, walking, and function in 88% of their subjects. Other authors have reported intermediate results using cemented total hip arthroplasty.⁴⁻¹²

Several features of cementless arthroplasty render it specific for rheumatoid patients. Growing evi-

dence has supported longevity of the noncemented primary total hip arthroplasty for osteoarthritic patients. Cementless THA has also gained support as the method of choice for revision surgery, particularly in patients with diminished quality of bone stock, in whom bone grafting is performed to facilitate biological fixation of the revision prosthesis.¹³

Cementless THA represents an attractive and theoretically advantageous alternative to cemented THA in rheumatoid arthritis patients with disabling hip involvement. Our investigation is a prospective clinical and radiographic evaluation of noncemented femoral components in total hip arthroplasty for patients with rheumatoid arthritis.

METHODS

PATIENTS

From 1982 through 1989, 22 patients with rheumatoid arthritis and five with juvenile rheumatoid arthritis underwent primary total hip arthroplasty and were prospectively studied using a modified Harris hip score. Of the 27 patients, two were lost to follow-up because they moved out of the area.

Of the remaining 25 patients, 22 were female and three were male (see Table 1). Their ages ranged from 14 to 69 with a mean operative age of 42.9 years. Nine patients, eight female and one male, underwent bilateral THA. Three of the patients had both hips operated on during the same general anesthetic; the other six had the two hips done at different times. In addition, four patients had previously undergone THA with a cemented femoral component in the contralateral hip prior to undergoing primary THA with the cementless component.

continued

Twenty-one study patients were diagnosed with rheumatoid arthritis and four were diagnosed with juvenile rheumatoid arthritis, with onset occurring before age 16. We classified the extent of disease involvement according to the American Rheumatism Association (ARA) Classification System. None of the patients were ARA Class I (small restrictions in range of motion, early radiographic changes and mild, if any, disability). We classified 14 patients as Class II, characterized by episodic symptoms and signs with marked limitation in range of motion and moderate to marked disability during active disease that improves when inactive. We identified seven as

Class III, characterized by progressive deterioration with decreasing range of motion, progressive radiographic deterioration, and moderate to marked disability. Finally, we classified four patients as Class IV, involving severe disability and confinement to a wheelchair or bed.

We initiated this study early in the development of the BIAS (Zimmer Inc.) femoral component. Early generation implants consisted of a titanium-collared prosthesis with a fixed 28mm head and 12 degrees of anteversion built into the neck. The stem of the prosthesis was bowed, to conform to the natural curve of the proximal femur. Titanium fiber mesh ingrowth pads were present over the anterior and posterior proximal surfaces. Later-generation components consisted of a modular system composed of varying size diameter heads with accompanying different size stems. At the outset of the study, the implants were custom manufactured for individual cases. Most recently, we employed the system of modular components.

We used three different acetabular designs during the study period. In the 34 primary total hip arthroplasties, we implanted 20 cemented acetabular cups, six bipolar prostheses, and eight noncemented, bony-ingrowth acetabula. Detailed results of these acetabular components are not discussed. Results, however, are included, where appropriate, for discussion of femoral components.

We performed all operations through a posterior approach. Postoperatively, patients followed a convalescence regimen consisting of ambulation with crutches prior to discharge, followed by weight bearing as tolerated until no further limp or discomfort existed.

CLINICAL EVALUATION

We graded patients using modified Harris hip scores of pain, limp, support, ambulatory distances, and

function, both preoperatively and at postoperative evaluations at six weeks, six months, and then yearly intervals from the date of surgery. The mean length of follow-up was five and one-half years with a range of two to eight years. Seventeen of the patients returned for follow-up within the past year. The eight remaining patients were contacted by telephone.

RADIOGRAPHIC EVALUATION

We obtained anterior-posterior and lateral radiographs of hips preoperatively and at postoperative evaluations of six weeks, six months, one year, and at yearly intervals thereafter. Using the six-week postoperative radiograph as a reference, we analyzed subsequent follow-up x-rays for prosthesis fit, axial subsidence, calcar resorption, and the presence of a radiopaque linear condensation. The mean period for radiographic follow-up was 4.6 years.

We assessed prosthetic fit by the presence of contact between the inner table of cortical bone and the prosthesis in addition to the completeness of prosthetic fit within the intramedullary canal. We graded the quality of the fit as good, fair, or poor. We measured axial subsidence on standard AP radiographs from the superior-most aspect of the greater trochanter to the superior-lateral aspect of the prosthesis. Evidence of endosteal condensation in the form of a radiopaque density, abutting the distal tip of the prosthesis or as a white line present along the length of the prosthesis, was documented on follow-up evaluation radiographs. Calcar resorption was evaluated on x-rays and graded as marked, moderate, mild, or no radiographic evidence of calcar resorption.

RESULTS

CLINICAL OUTCOME

The mean preoperative total hip score was 48, with a range of 31 to 68. The mean postoperative total score at latest follow-up was 80, with a range of 44 to 95. An excellent score (90-95) was recorded in nine cases (27.3%), a good score (80-89) was recorded in 12 cases (36.3%), a fair

Table 1

Demographics

Sex	Female	Male
	22	3
Diagnosis	Rheumatoid arthritis	Juv. rheum. arthritis
	21	4
ARA classification	Class I	Class II
	none	14
	Class III	Class IV
	7	4
Age	Range	Mean
	14-69 yrs.	42.9 yrs.
Follow-up	Range	Mean
	2-8 yrs	5.5 yrs

Table 2

Results

Table 2		
<i>Results</i>		
	Range	Mean
Preoperative Harris hip score	31-68	48
Postoperative Harris hip score	44-95	80

Postoperative results	Score	Hips	Percent
Excellent	90-95	9	27.3%
Good	80-89	12	36.3%
Fair	70-79	7	21.2%
Poor	<70	5	15.1%

result (70-79) was recorded in seven cases (21.2%), and a poor result (<70) was recorded in five patients (15.1%). One patient underwent revision of her femoral component and was not included in the results (see Table 2).

Pain: At latest follow-up, 19 hips (58%) of the 33 hips included in the study were free of pain. Slight, occasional discomfort requiring no medication was experienced in seven hips (21%). Although mild pain was present in three hips (9%), which required occasional anti-inflammatory medication, these patients experienced no effect on daily activities. Moderate pain, defined as tolerable in four (12%) hips, required patients to make concessions or to take an occasional narcotic analgesic. At latest follow-up, total disability was not found in any patient who underwent THA.

Limp: Absence of limp was reported in 15 (46%) of the 33 hip replacements. A slight limp was recorded in 14 (42%), and a moderate limp was detected in four THAs (12%). No patients experienced severe limp at their latest follow-up.

Support: Twenty-three hips (70%) required no support for ambulation following surgery. Use of cane on long walks (approximately six blocks or more) was necessary in seven (21%) of the cases. One patient with one THA (3%) used a cane for assistance at all times. The use of a crutch support at all times was reported for two hips (6%).

Distance: Sixteen (47%) THAs resulted in no limitation in distance walked. In 10 (29%) cases, the patients could walk approximately six blocks; seven THAs (21%) enabled patients to walk two to three blocks.

Functional activities: We assessed the patients' functional abilities through examination of several activities, including ability to ascend and descend stairs, to put on socks and to tie their shoes, to use public transportation, and to sit in a chair without limitations. Eleven (33%) hips produced no limit to patients' functional abilities, 18 (56%) resulted in mild limitations, and four (12%) hips had moderate limitations to their activities.

Table 3

Radiographic results (reported as number of hips and percent of total)

Prosthetic fit	Good 20 (65%)	Fair 6 (19%)	Poor 5 (16%)	
Subsidence	<2mm 27 (87%)	3-10mm 4 (13%)	10mm 0	
Condensation	Mild 18 (58%)	Moderate 9 (29%)	Marked 4 (13%)	
Calcar Resorption	None 13 (42%)	Mild 9 (29%)	Moderate 8 (26%)	Severe 1 (3%)

RADIOGRAPHIC ANALYSIS

Radiographic evaluation was performed on all but three patients in this study (see Table 3). Two patients moved and had their radiographs forwarded to an orthopedic surgeon in closer proximity for routine follow-up, and one patient wished to have her radiographs sent to a second orthopedic surgeon. For the eight patients who participated in follow-up by telephone, radiographs from within the previous 12 months were not available.

Fit: Twenty of the 31 hips evaluated by radiograph (65%) exhibited good prosthetic fit. Six (19%) showed fair fit, and five THAs (16%) exhibited poor fit.

Subsidence: Twenty-seven (87%) hips showed less than 2mm of subsidence. Four (13%) exhibited subsidence between 3mm and 10mm, while none of the hips had greater than 10mm of axial subsidence.

Condensation: Eighteen hips (58%) exhibited mild condensation, nine (29%) showed moderate condensation, and four (13%) had evidence of marked endosteal condensation.

Calcar resorption: Thirteen (42%) hips exhibited no evidence of calcar resorption, while mild calcar resorption was present in nine (29%) hips. Moderate resorption was observed in eight (26%) hips, and one (3%) hip underwent severe resorption.

RADIOGRAPHIC AND CLINICAL CORRELATION

We employed a Pearson Correlation Matrix with corresponding probability matrix to compare age, height, weight, and ARA class with the individual Harris hip score categories of pain, limp, support, distance, function, and total hip score, as well as with the radiographic descriptors of fit, subsidence, linear condensation, and calcar resorption. We also compared clinical categories with each of the radiographic categories.

We identified three statistically significant correlations. We identified a correlation between height and radiographic evidence of calcar resorption (a Pearson Correlation Matrix Value of 0.494, probability=0.032). Pain correlated with condensation (a Pearson Correlation Matrix Value of 0.358, probability=0.048). Finally, distance correlated with calcar resorption (a Pearson Correlation Matrix Value of 0.456, probability=0.010). No other significant correlations were identified. We also compared acetabular components with different clinical and radiographic outcome criteria and found no statistically significant correlation.

COMPLICATIONS

Six complications arose involving the 34 procedures. Two patients experienced dislocations in the perioperative period. We performed revision surgery in four patients, three for

acetabular component revision and one for both femoral and acetabular component revision. No deep infections or nerve palsies were sustained.

POOR RESULTS

Five hip replacements in five patients had poor clinical results, defined as a Harris hip score of less than 70, at latest follow-up. All of these patients experienced significant multiple joint involvement in their disease process. In addition, one patient suffered from bilateral involvement of his hips, shoulders, hands, and feet, which produced marked limitations of function. Another patient underwent bilateral total knee replacements 14 months prior to undergoing bilateral total hip replacements. She had a fair result with one THA and a poor result with the second. One patient who experienced a poor clinical result had multiple joint involvement resulting in generalized poor functional performance and mild postoperative pain.

ACETABULAR COMPONENTS

We used three different generations of acetabular components during the course of this study: cemented acetabular cups in 20 patients, bipolar cups in six cases, and in eight cases, noncemented acetabular prostheses were used. In patients receiving cemented acetabular components, two (10%) required revision and one (5%) experienced dislocation requiring nonsurgical reduction. For patients receiving bipolar acetabular components, one (17%) required revision and none experienced dislocation. Finally, for the eight patients who received noncemented acetabular components, one (12.5%) required revision and one (12.5%) experienced dislocation requiring nonsurgical reduction.

DISCUSSION

Statistically significant correlations between radiographic findings and clinical outcomes are few. Though several categories can be identified as containing a statistical difference, it is not possible to identify any particular radiographic finding as a reliable predictor of clinical outcome.

Examination of the results of this investigation reveal several salient findings. The mean preoperative score was 45, and the mean score at latest follow-up was 80. Both of these figures represent a significant difference from the total hip score frequently seen in patients with osteoarthritis who undergo noncemented total hip arthroplasty. Thus, the rheumatoid arthritis patient may achieve a very significant, albeit limited, improvement with total hip arthroplasty.

Second, the systemic nature of this disease frequently produces multiple joint involvement. Interestingly, three patients in this study experienced increased involvement of other lower extremity joints following total hip replacement. Prior to surgery, their hip involvement limited their functional activity. With the resolution or improvement of their hip discomfort postoperatively, these patients consequently experienced progression of the disease process affecting other joints, which resulted in limited overall postoperative improvement.

Perhaps most important, examination of the composite results of this investigation reveals the following: at latest follow-up, approximately 82% of our patients experienced significant improvement in their conditions. In addition, 89% of the patients who underwent this procedure experienced either complete resolution or marked improvement of their pain to such a degree that it no longer affected their ability to perform daily activities. In 88% of our patients, functional capabilities improved to a degree that the individuals now experience either mild or no limitation to their functional abilities.

Finally, three patients required revision of the acetabular component, and one patient required revision of both the acetabular and femoral components. The acetabular components requiring revision were uniformly distributed among the different types of components employed and represent an acetabular revision rate of 12%. The revision rate for the noncemented femoral components in this study was 3%. These results support the conclusion that the acetabular component is more likely to

require revision than is the femoral component in total hip arthroplasty in the rheumatoid patient.

CONCLUSION

In patients with rheumatoid arthritis, total hip arthroplasty employing a noncemented femoral component is a safe and reliable means of restoring function and resolving pain. A significant number of patients will continue to experience functional limitations as a result of the generalized, systemic nature of this disease. The surgeon performing THA in these patients should have as a goal improving the patient's comfort and hip function while recognizing the intrinsic limitations that are a result of the underlying disease. MM

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REFERENCES

1. Isdale IC. Hip disease in juvenile rheumatoid arthritis. *Ann Rheum Dis* 1970;29:603-8.
2. Unger AS, Inglis AE, Ranawat CS, Johanson NA. Total hip arthroplasty in rheumatoid arthritis. *J Arthroplasty* 1987;2(3):191-7.
3. Poss R, Maloney JP, Edwald FC, et al. Six to eleven year results of total hip arthroplasty in rheumatoid arthritis. *Clin Orthop* 1984;182:109-16.
4. Arden GP, Ansell BM, Hunter MJ. Total hip replacement in juvenile chronic arthritis and ankylosing spondylitis. *Clin Orthop* 1972;84:130-6.
5. Colville J, Raunio P. Total hip replacement in juvenile rheumatoid arthritis. *Acta Orthop Scand* 1979;50:197-203.
6. Gudmundsson GH, Harving S, Pilgaard S. The Charnley total hip arthroplasty in juvenile rheumatoid arthritis patients. *Orthopedics* 1989;12(3):385-8.
7. Lachiewicz PF, McCaskill B, Inglis A, Ranawat CS, Rosenstein BD. Total hip

- arthroplasty in juvenile rheumatoid arthritis. J Bone Joint Surg Am 1986;68-A:502-8.
8. Ranawat CS, Dorr LD, Inglis AE. Total hip arthroplasty in protrusio acetabuli of rheumatoid arthritis. J Bone Joint Surg Am 1984;62-A:1059-65.
9. Scott RD, Sarokhan AJ, Dalziel R. Total hip and total knee arthroplasty in juvenile rheumatoid arthritis. Clin Orthop 1978;21:401-6.
10. Singsen BH, Isaac AS, Bernstein BH, et al. Total hip replacement in children with arthritis. Arthritis Rheum 1978;21:401-6.
11. Gruen TA, McNeice GM, Amstutz HC. "Modes of failure" of cemented stem-type femoral components. Clin Orthop 1979;14:17-27.
12. Collis DK. Cemented total hip replacement in patients who are less than fifty years old. J Bone Joint Surg Am 1984;66-A:353-9.
13. Kyle RF, Gustilo RB. Revision total hip arthroplasty with the bias total hip system. Techniques in Orthopaedics 1987;2:7-19.

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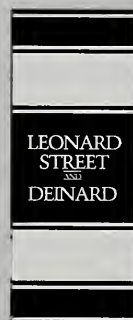
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ANNOUNCEMENTS

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MMA RESOLUTIONS ARE DUE JULY 15

Resolutions to the 1995 Minnesota Medical Association House of Delegates should be submitted to the MMA office by Monday, July 15, to allow time for reproduction and distribution to the delegates.

The 143rd MMA Annual Meeting will be held at the Northland Inn in Brooklyn Park September 18 to 20, 1996. The House of Delegates will be in session on Thursday, September 19, and Friday, September 20.

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MMA E-MAIL

You can now send E-mail directly to MMA staff. The E-mail address is: the initial of the first name, the last name, followed by: @mnmed.org

For example, the E-mail address of *The Monitor* editor is: lholmngren@mnmed.org

The E-mail address of the MMA is: mma@mnmed.org

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DR. SMITH IS ELECTED MMIC BOARD PRESIDENT

Andrew J.K. Smith, M.D., was elected president of the Midwest Medical Insurance Company Board of Directors following his re-election as a member of the MMIC board. Smith, a Minneapolis neurosurgeon, has been a member of the MMIC board for six years. An active member of the MMA, Smith has served as MMA president and as chair of the MMA Board of Trustees.

The MMA Board of Trustees also elected the following physicians to serve on the MMIC Board of Directors: Gail P. Bender, M.D., Anthony C. Jaspers, M.D., and Mark D. Odland, M.D.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Urges Changes in Fraud and Abuse Provisions

Thanks to a grassroots effort by organized medicine, fraud and abuse provisions that could have subjected physicians to fines and criminal penalties for activities they did not know were illegal may be removed from the conference report on the U.S. health insurance bill. The Minnesota Medical Association and the Minnesota Hospital and Healthcare Partnership urged U.S. House and Senate conferees on the health insurance bill H.R. 3103 to change a number of provisions. "Clarity in the law and emphasis on compliance and education are crucial, in addition to providing enforcers with the tools needed to stop abuses," wrote Paul Sanders, M.D., MMA chief executive officer, and Stephen Rogness, MHHP president.

The health insurance bill, introduced by Sens. Nancy Kassebaum, R-Kan., and Edward Kennedy, D-Mass., is intended to make it easier for people who change jobs or who have preexisting medical conditions to buy and keep health insurance, but the bill also includes controversial fraud and abuse provisions. There are a number of differences between the House and Senate bills that are being resolved by the conference committee.

The MMA and MHHP urged the conferees to make the following changes in fraud and abuse provisions:

- Include a requirement that there be "knowing and willful intent" to violate the new federal health care offenses in H.R. 3103.
- Link civil monetary penalties

to the amount of the inappropriate claim in order to avoid enormous, disproportionate penalties. Include the House language that sets a "knowledge" standard for civil monetary penalties so that physicians will not have to pay penalties for activities they did not know were prohibited.

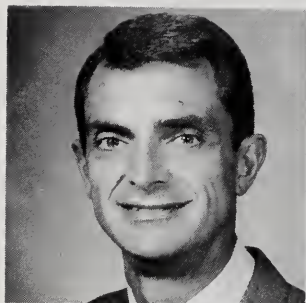
- Delete provisions in the House and Senate bills that would allow innocent coding decisions to trigger civil monetary penalties.

- Retain the exception for provider risk-sharing and discount arrangements passed by both the House and Senate. "In today's dynamic health care environment, it is important to allow the Medicare and Medicaid programs to use certain arrangements that are common in the private sector and enhance competition, promote quality, and control utilization," the MMA/MHHP letter said.

- Keep the House language that would enable physicians to obtain binding advisory opinions from enforcement agencies as to whether certain conduct would violate the law.

- Avoid making a link between fines and funding that might create improper incentives for enforcers. The House and Senate bills would establish a Health Care Fraud and Abuse Control Account to be funded through the Hospital Insurance Trust Fund, into which flow the fines, penalties, and damages collected from law enforcement activities. The original proposal for the account had

Fraud continued on page 35



Viewpoint

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Michael J. Murray, M.D.
President, Minnesota Medical Association

Physicians Stand Firm Against Assisted Suicide

"I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrongdoing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course."
Hippocrates, 460-377 B.C.

More than 2,000 years ago, Hippocrates set an ethical standard that still guides physicians. Now this core value of our profession—the belief that it is wrong to help a patient commit suicide—is being assailed by the courts and by public opinion.

The 9th U.S. Circuit Court of Appeals overturned a Washington state law against physician-assisted suicide that had been in place since 1854 and held that a mentally competent, terminally ill adult has a constitutional right to seek a doctor's help in hastening death.

The 2nd U.S. Circuit Court of Appeals struck down New York's ban on physician-assisted suicide. The ruling allows physicians to prescribe drugs to be self-administered by a patient in the final stage of a terminal illness. New York is appealing the decision.

The 2nd Circuit found no basis for distinguishing between withdrawing life support at the patient's request and actively helping a patient

commit suicide. To me, the line seems very clear. Choosing not to take extraordinary measures to prevent a natural death is much different from taking direct action to end a life or assisting a patient to do so.

The final legal verdict is not in; New York is appealing to the Supreme Court and Washington may follow suit. But for physicians, the decision will not be made in the courts or in public opinion polls. Our professional code of ethics is very clear. We are healers and, as such, cannot assist in our patients' suicide—even if they wish to die.

The trend toward supporting physician-assisted suicide is disturbing. It is important for us to address the factors that may be contributing to this shift in traditional beliefs. In an era of technological marvels, people may fear loss of control or loss of dignity at the end of life. They may fear dying slowly in terrible pain or lingering on life support when their mind has gone or becoming a burden to their family. These are legitimate concerns. We can offer reassurance and comfort by talking to our patients about making a living will and about home health care. Perhaps most important, we can refer those patients with terminal illnesses for hospice care and, for those patients in intractable pain, we can provide enough medication to relieve pain.

There may be some confusion among the public about the ethical

distinction between prescribing enough medication to relieve pain for a terminally ill patient—even if we know this may hasten death—and prescribing medication for the specific purpose of ending a life. Prescribing enough medication to keep a dying patient comfortable is not only appropriate, it may actually prevent people from committing suicide.

If we look at the experience of the Netherlands where assisted suicide and euthanasia are "legal," we can see the dangers that await us if we proceed down that path. A 1983 study in the Netherlands showed that the family requested euthanasia more often than the patient. Research shows that Dutch doctors support the relatives' desire to be free of the burden of caring for the patient, and they are less interested in relieving pain. Doctors find euthanasia an easier alternative even when the patient is not terminally ill. In most cases, euthanasia is performed without the patient's consent.

The Netherlands example should make us skeptical about the "right to die." Will the right to die become an obligation to die? In an article in the *New York Times*, Herbert Hendin wrote about a 52-year-old woman suffering from multiple sclerosis whose decision to commit suicide was strongly influenced by her husband's wish to be free of the drudgery of caring for her. Hendin cited a 1989 Swedish study showing that when chronically ill patients attempted suicide, their families often did not want them revived. But when society helped the family by providing home care such as nursing, feeding, bathing, and companionship, the patients *did* want to live, and their families wanted them to live as well.

Despite possible changes in the law, our ethical position is clear: If patients ask us to help them commit suicide, we must refuse. But we may offer healing alternatives such as home care, reassure them that enough pain-relieving drugs will be provided, and tell them about hospice alternatives.

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Fraud continued from page 33

ines and penalties flowing directly to enforcers. In response to concerns raised last year, the direct link between fines and funding was modified. The MMA remains concerned, however, that even an indirect link might create an inappropriate "bounty system" that could impair objective implementation of the law. The MMA also questions whether using Medicare funds to support efforts in the private sector is a prudent use of federal resources.

- Allow physicians to provide input into the development of any new Medicare commercial coding technologies. Both the House and Senate bills would require the use of new commercial software products, which raises the possibility of "black box" review screens. The manufacturer of the product might refuse to disclose the content of the technology,

claiming that such information should be private. The MMA urged conferees to amend these provisions to reflect the public nature of the Medicare program and to allow for the appropriate review of these commercial products.

As *The Monitor* goes to press, House and Senate Republicans have resolved their differences on the Kennedy-Kassebaum bill as a preliminary step toward reaching agreement on the formal House and Senate conference report. According to the AMA, Republicans have agreed to adopt the "knowing and willful" standard, to apply fines only if a physician showed reckless disregard for the truth in dealings with the Medicare program, and to retain the binding advisory opinion process. These are major improvements in the fraud and abuse provisions, and the AMA is now expected to support

the conference bill.

The Republicans also agreed on a medical savings account option that would limit MSAs to small businesses with 50 or fewer employees and the self-employed. In three years, larger employers would be eligible for the MSA option. Democrats in Congress and the Clinton Administration, however, favor a more limited MSA demonstration project. Disagreement over MSAs could stall Senate passage or lead to a veto. The Senate provision requiring insurers to treat mental health conditions on a par with physical health problems, which was proposed by Sen. Paul Wellstone, D-Minnesota, is expected to be scaled back to a study commission rather than a new requirement for insurance policies.

As *The Monitor* goes to press, the fate of the insurance bill remains uncertain. • • • • •

LEGAL NEWS

NINTH CIRCUIT DECLINES TO RECONSIDER RULING ALLOWING ASSISTED SUICIDE

The U.S. Court of Appeals for the 9th Circuit decided not to reconsider its ruling that Washington state's ban on assisted suicide is unconstitutional. In March, the 9th Circuit struck down Washington's ban on physician-assisted suicide in an 8-3 decision. Later, however, the 9th Circuit asked both parties for briefs on whether all 25 appellate court judges should review the case. Now that the appeals court has declined to reconsider its decision, Washington may appeal. The state has until July 3 to file a petition with the U.S. Supreme Court for review of the appeals court decision.

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NEW YORK APPEALS 2ND CIRCUIT RULING ON ASSISTED SUICIDE

As expected, New York state has asked the U.S. Supreme Court to review a ruling by the U.S. Court of Appeals for the 2nd Circuit that struck down New York's ban on assisted suicide. The petition argues that the 2nd Circuit's reasoning conflicts with a decision by the highest state court in Michigan and differs from a ruling of the 9th Circuit. Although both the 9th Circuit and the 2nd Circuit found bans on assisted suicide to be unconstitutional, they did so for different reasons. The 2nd Circuit ruled that New York's ban on assisted suicide violated equal

protection rights, and the 9th Circuit found that Washington's ban on assisted suicide violated due process rights. New York's petition asked the Supreme Court to review whether under the equal protection clause of the 14th Amendment to the Constitution, the state retains a legitimate interest in banning assisted suicide while allowing terminally ill, mentally competent patients to refuse artificial life support. The petition also asks the Supreme Court to resolve a conflict between the 2nd Circuit ruling and the Michigan Supreme Court decision upholding the state ban on physician-assisted suicide and rejecting a challenge by Jack Kevorkian, M.D.

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ANNOUNCEMENTS

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METRAHEALTH IS DEVELOPING MEDICAL REVIEW POLICIES

Minnesota's Part B Medicare carrier, MetraHealth, is in the process of proposing two medical review policies—one for radiologic examination of the chest and one for the removal of benign skin lesions. These model policies were developed nationally in an effort to achieve greater national standardization in Medicare coverage policy. MetraHealth currently has a local policy in place for the removal of benign skin lesions; the proposed policy is more restrictive and could have an impact on physicians. Both policies have been disseminated to the physician representatives on the Medicare Carrier Advisory Committee. If you are interested in reviewing the proposed changes, call Janet Silversmith at the MMA, 612/378-1875 or 800/999-1875. The deadline for submitting comments to MetraHealth is July 15, 1996.

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COUNCIL FOR PREVENTIVE MEDICINE SEEKS MEMBERS

Physicians who are interested in public health and preventive medicine are invited to join the Council for Preventive Medicine, a physician organization dedicated to the prevention of disease and injury. Early in its development, the council provided consultation on a fetal alcohol syndrome prevention project, funded by the Minnesota Department of Health. Currently, the council is developing proposals on traffic safety, firearm injury prevention, and environmental health. Annual dues are \$35. For more information about the council, call 612/427-5310.

MMA Calls Geographic Coalition Meeting

The Minnesota Medical Association called a meeting of the Geographic Coalition in Chicago June 24 to discuss strategies to correct the geographic inequities in Medicare reimbursement. The coalition of 35 state medical societies was co-founded in 1989 by the MMA and the Utah Medical Society to work together to achieve a fair Medicare reimbursement system.

As *The Monitor* goes to press, plans for the meeting, held in conjunction with the American Medical Association Annual Meeting, call for Michael J. Murray, M.D., MMA president, to welcome coalition members and introduce guest speakers; Thomas Reardon, M.D., vice chair of the AMA Board of Trustees, to present the AMA Board's perspective; Sandra Sherman, director of

physician payment systems in the AMA Payment Programs Division, to address the Health Care Financing Administration's practice expense relative value unit component study and the fee-for-service payment system; Jim Moser, senior economist and director of research publications at the AMA Center for Health Policy Research, to discuss managed care payment and the adjusted average per capita cost; and Richard A. Deem of the AMA Federal Affairs department, to explain the role of Congress. At the conclusion of the meeting, Murray plans to lead a discussion on the major question: Where do we go from here?

See the August *Monitor* for results of the Geographic Coalition meeting.

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MMA Workshops Show How to Use the Internet

Learn how your practice can benefit from the Internet and the World Wide Web at an MMA workshop for physicians July 24 at 7:30 a.m. in St. Paul. A workshop for clinic managers will follow at 10 a.m.

Internet Opportunities for Your Practice

- Find out how to choose an access provider, what equipment you will need, how much it will cost, and much more.
- Learn how to link offices, access medical information, and join on-line medical forums. You'll also be able to access news about the stock market, travel, sports, arts, and recreation.

Introduction to the Internet for Physicians will be presented July 24, 7:30 a.m. to 9 a.m. at the Sheraton Inn Midway Hotel in St. Paul. The \$59 registration fee includes a continental breakfast.

Internet Fundamentals for Medical Practice Managers will be presented July 24 from 10 a.m. to 1 p.m. at the Sheraton Inn Midway. The \$99 registration fee includes a box lunch.

The workshops are presented by the Minnesota Medical Association and Learning Ventures. For more information, or to register, call Vicki Westling at 612/362-3764 or 800/999-1875.

ANNOUNCEMENTS

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MMA BOARD ACCEPTS OFFICER NOMINATIONS

The Minnesota Medical Association Board of Trustees has accepted the following slate of nominees for 1995-96 MMA offices:

President-elect:

Kent S. Wilson, M.D.

Secretary:

Judith F. Shank, M.D.

Treasurer:

Noel R. Peterson, M.D.

Speaker of the House:

Anthony C. Jaspers, M.D.

Vice Speaker of the House:

Blanton Bessinger, M.D.

Vice President:

Paul R. Hamann, M.D.

Nominations for MMA offices will remain open through the first session of the House of Delegates September 19 at the MMA Annual Meeting.

The following members of the Minnesota delegation to the AMA are up for reelection:

Delegates

Robert D. Christensen, M.D.

E. Duane Engstrom, M.D.

Audrey M. Nelson, M.D.

Alternate Delegates

Theodore L. Fritsche, M.D.

Frank J. Indihar, M.D.

Carolyn J. McKay, M.D.

National Rural Conference Focuses on Managed Care

"Get ready. Managed care is coming to rural America," was a clear message at the National Rural Health Association's 19th annual national conference in Minneapolis in May. Keynote speaker Steven Schroeder, M.D., president of the Robert Wood Johnson Foundation, called managed care "a huge unannounced experiment," and predicted it would receive closer scrutiny now that journalists throughout the country are finding themselves in managed health care plans. Schroeder said RWJ is beginning to shine the spotlight on managed care with a health tracking project. At this point, more questions have been raised than answered, he said, among them whether or not physician-managers will be more humane than business-oriented managers.

Threats and Opportunities

Ray Christensen, M.D., MMA president-elect, spoke about "Opportunities and Threats Coming to Your Rural Town." Christensen, a family practitioner at Gateway Family Health Clinic in Moose Lake, said that managed care is not too much of a change for a family practitioner. "We always took care of whoever came through the door; we knew our limitations and referred appropriately." Christensen believes that if the patient base is large enough, capitation can work in rural areas, but it's important to find creative local solutions and work with other communities.

Christensen stressed the importance of building community support in order to retain the local patient base. Physicians in rural towns, such as Moose Lake where Christensen practices, often lose patients to Duluth or other large cities. "I don't know why," Christensen said. "Most of us trained in the same place. Maybe it reflects the quirkiness of all of us who live in rural areas. But at two in the morning we

see a lot of Duluth patients." Christensen recommended that physicians sit down on a routine basis with the city leaders and talk to them about what their clinic brings to the community in terms of jobs, income, business, tourists, retirees, and security for residents. "It's important to build community understanding and support and to draw the connection between the community's health care and its economic development," Christensen said.

Managed care puts more emphasis on efficiency and cost. The change requires a paradigm shift from focusing on the individual practice to the community, according to Christensen. Difficult questions arise. Where does public health, medical education, mental health care, and long-term care fit into the picture? Who pays for what? How much is the state government responsible for? What is the responsibility of the health plans?

What Does the Future Hold?

In the future, the definition of "community" may change, Christensen said. Neighboring rural communities may form partnerships. He predicted more integration of allied health professionals into the practice, more reliance on satellite clinics, and increasing use of telemedicine. "Technology makes geography surmountable," Christensen said. Managed care "know how" will be important, as well as information systems and computer records. There will be more concern with patient satisfaction.

As change comes to rural areas, physicians should evaluate how relevant their organization is now and ask themselves: How relevant will it be in five or 10 years? Can the practice remain independent? Instead of resisting change, Christensen recommended that rural physicians invest in making change work. • • • • •

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MMA WINS MSAE AWARD

The Minnesota Society of Association Executives has given the Minnesota Medical Association an Associations Advance Minnesota Award for its "Stop the Media Violence" campaign, which was designed to increase public awareness about media violence and the effect it is having on society. The award, which recognizes outstanding programming in community services, was presented to Mark Vukelich, MMA director of communications, during a special EXPO Awards luncheon in June. The MSAE issued the following statement regarding the MMA campaign: "This well-designed project brought together many agencies and individuals with a common goal. The American Medical Association and the National Association of Attorneys General will be adopting the campaign and using it on a national basis. This is a wonderful example of how associations can serve to educate and inform many different publics to improve our quality of life."

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MMA SPONSORS CRITICAL VIEWING CONFERENCE

The MMA was one of the sponsors of the workshop, "Taking Charge of Your TV," at St. John's University in Collegeville on May 18. Speakers included Attorney General Hubert H. Humphrey III; Mark Vukelich, MMA director of communications; and David Walsh, Ph.D., a psychologist who has served as an MMA spokesperson on the topic of media violence and its effect on children. Among the participants were MMA members Edmund C. Burke, M.D., John W. Wahl, M.D., and Kathleen Sweetman, M.D., and MMA alliance member Kendra Flanagan.

AMA President Honors Minnesota Anti-Violence Efforts

**Bristow Visits Duluth**

At a news conference in Duluth, Lonnie Bristow, M.D., American Medical Association president, presented the AMA President's Award of Excellence to the Duluth Domestic Violence Intervention Project. The AMA honored the project for creating protocols that help Duluth physicians, law enforcement officers, therapists, and others join in a coordinated community response to domestic violence. Calling the project a "national model of a coordinated community response," Bristow said that although domestic violence creates headlines of "uncommon hopelessness and despair," the real news story is stopping the violence and starting the cure. "And it's especially the story here, today, in Duluth—because of some very special efforts by the Minnesota Medical Association ... to stop the violence."

The MMA presented its "Stop the Violence" Award to the Duluth Intervention Project at the 1994 MMA Annual Meeting. "Today, the

AMA is here to second the motion—and to raise the flag higher," Bristow said.

The MMA helped arrange Bristow's media tour in Duluth, where Bristow met with Duluth Clinic physicians, mini-internship participants, MMA Board members, AMA delegates, MMA staff, hospital and clinic administrators, Range Medical Society members, and members of the Lake Superior Medical Society Executive Committee and Legislative Committee.

Minnesota Alliance Wins Award

Bristow presented the AMA Alliance's SAVE award to the Zumbro Valley Alliance on June 23 in Chicago in conjunction with the AMA Annual Meeting. The AMA Alliance honored the Zumbro Valley Alliance for its antiviolence activities during SAVE week in Rochester in October 1995. Carolyn Rorie, past president of the Zumbro Valley Alliance, accepted the award. • • • • •

BHCAG Defends Its Exclusive Contracts

During the Minnesota Medical Association's ongoing discussions with the Buyers Health Care Action Group regarding the direct contracting approach to health care delivery, the MMA raised concerns about BHCAG's requirement that primary care physicians participate in only one care system. In response, Steve Wetzell, executive director of BHCAG, sent the MMA a letter, outlining BHCAG's rationale for its exclusivity requirement and stressing that the exclusivity requirement applies only to care systems for the BHCAG Choice Plus Plan.

"When primary care physicians participate in multiple care systems, group purchasers and consumers can no longer distinguish their performance in terms of either cost or quality," Wetzell wrote. "Because all networks end up with the same or very similar panels of providers, we

cannot identify provider performance either clinically or financially."

Wetzell acknowledged that historically, a primary care physician's best financial strategy has been to sign contracts with as many health plans as possible and, thus, attract a steady stream of patients. But he believes there are also disadvantages for the primary care provider who participates in many different care systems. "Primary care doctors lose their power to determine which specialties they want to refer to, which drugs they want to prescribe, and what protocols they want to follow without adversely affecting the insurance coverage their patient receives."

Wetzell said that BHCAG's requirement is not intended to apply to any other health plan or contractual arrangement in which primary care physicians participate.

AG Proposes Media Violence Resolution at NAAG Conference

At the summer meeting of the National Association of Attorneys General (NAAG), Attorney General Hubert H. Humphrey III proposed a resolution calling on NAAG to encourage each attorney general to consider establishing partnerships with the state medical association and others to address the issue of violence in the media. "The Minnesota Medical Association and the Minnesota Attorney General's Office have developed a successful model campaign against violence in the media that other attorneys general may wish to adapt in their state," Humphrey said. He outlined the highlights of the MMA/AG campaign, which included a news conference; brochures, posters, buttons, and bumper stickers; radio and television public service announcements;

articles in MMA and AG publications; participation in Vice President Al Gore's national conference on the family and the media; and participation in the Media Literacy Working Group training session, "Taking Charge of Your TV," and in the Corporate Responsibility Working Group that is developing voluntary standards for the types of programming that corporations should support through advertising.

NAAG adopted Humphrey's resolution, which also applauds the AMA's public awareness campaign on media violence and encourages NAAG to work with the AMA and other groups to collect and identify specific strategies that attorneys general can use to promote public awareness programs on media violence.

Criterion Will Fold

BHCAG's exclusivity requirement proved to be the last straw for the struggling Criterion Healthcare Network. The network was already having difficulty getting contracts with the health plans and raising enough revenue to continue. BHCAG's requirement that primary care physicians participate in only one care system forced the primary care physicians to choose between the new and unproven Criterion and large hospital networks. "Their hearts were with Criterion but their pocket books and futures were with the larger networks," said Andrew J.K. Smith, M.D., a member of Criterion's board of directors and one of the physicians who spearheaded the formation of the physician network. Richard Streu, M.D., a primary care physician and member of Criterion's board, agreed that BHCAG's decision was just the "final nail" for Criterion, which had been struggling through three or four years of frustration trying to deal with the insurance companies. Hopes that BHCAG would select Criterion as one of the care systems it considered best were dashed when BHCAG accepted all the care system proposals. "Finally, Criterion couldn't provide enough patients to make it viable for physicians," said Streu. Criterion is now in the process of winding down its operation.

MMA Publicizes AMA Report Card on Violence

The MMA sent out a news release publicizing the AMA's Annual Report Card on Violence, which gave the nation an overall grade of D, despite some slight improvements. This year's Report Card rewards an increase in public awareness and new federal and local initiatives aimed at ending family violence and entertainment violence with a slight grade increase of C and D+, respectively, but a D- in sexual assault and an F in public violence to keep the overall average grade firmly at a D.

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ANNOUNCEMENTS

STATE PROGRAMS COVER BONE MARROW TRANSPLANTS

As of January 1, 1996, the Department of Human Services began covering autologous bone marrow transplants for breast cancer for recipients of Minnesota health care programs. The transplant facility must: 1) be approved by DHS as meeting American Society of Hematology and Clinical Oncology criteria to perform bone marrow transplants; 2) be a participating provider of services in the Medicare program; 3) be located in the state of Minnesota; 4) submit a written prior authorization request to DHS for

each transplant; and 5) meet all other program requirements as described in the Minnesota Health Care Provider manual.

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NEW ELECTRONIC TAX SYSTEM REQUIRES ACTION

Effective January 1, 1997, the Internal Revenue Service will expand the number of businesses and nonprofit organizations that are required to pay federal taxes by electronic funds transfer. Business and nonprofit taxpayers whose 1995 federal employment tax deposits exceeded \$50,000 must act promptly or risk incurring penalties of 10 percent or more on each tax deposit, according to John P. James, an attorney with Fredrikson & Byron, P.A., in Minneapolis.

In addition, the current TaxLink electronic payment system is being replaced by the Electronic Federal Tax Payment System. Taxpayers will be allowed to enroll in the new EFTPS sometime this summer, and affected taxpayers *must* enroll by November 1, 1996. January 1 is the deadline for affected businesses to begin making their federal tax deposit payments through the new EFTPS. The phone number for the EFTPS Customer Service Center is 800/945-8400.

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GROUP PRACTICE ATTESTATION DEADLINE STILL DELAYED

The deadline for group practices to file a statement with their Medicare carriers attesting that their practice meets the requirements for the group practice exception was delayed in a final rule published in December 1995. The group practice attestation will be due 60 days after instructions are received from your Medicare carrier. As *The Monitor* goes to press, final instructions have not yet been issued to any Medicare carrier.

Watch *The Monitor* for further developments.

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LEGISLATIVE HEARINGS WILL FOCUS ON EMS ISSUES

A series of hearings will be held throughout the state to identify the emergency medical services issues facing Minnesota in the next decade. Interested legislators will attend, and members of the public and local government officials are also encouraged to participate. The schedule of hearings follows.

July 15, St. Paul, 2 p.m. to 4 p.m., United Hospital-Heart/Lung Building

July 15, Mankato, 7 p.m. to 9 p.m., South Central Technical College

July 16, Willmar, 7 p.m. to 9 p.m., location pending

July 17, Duluth, 7 p.m. to 9 p.m., location pending

July 18, Perham, 7 p.m. to 9 p.m., Perham Community Center

For more information, call O.J. Doyle at 612/526-4458.

ANNOUNCEMENTS

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MMA OFFERS COLLECTION AND RECEPTIONIST WORKSHOPS

The Minnesota Medical Association and Allied Interstate, Inc., will present workshops for your accounts receivable, business office, and point-of-service personnel on July 30 at the Sheraton Inn Midway in St. Paul.

Telephone Collection
8:30 a.m. to 12:00 noon
Highlights include:

- Seven steps to a successful collection call;
- Telephone "do's and don'ts"; and
- How to handle common situations.

Receptionist Workshop
1 p.m. to 4:30 p.m.
Highlights include:

- Telephone techniques;
- Seven-step method of quality service; and
- How to handle complaints and angry clients.

The registration fee is \$75 per person/per workshop. For more information, call Vicki Westling at the MMA, 612/362-3764 or 800/999-1875.

The Monitor
JULY 1996
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PRESIDENT

Michael J. Murray, M.D.

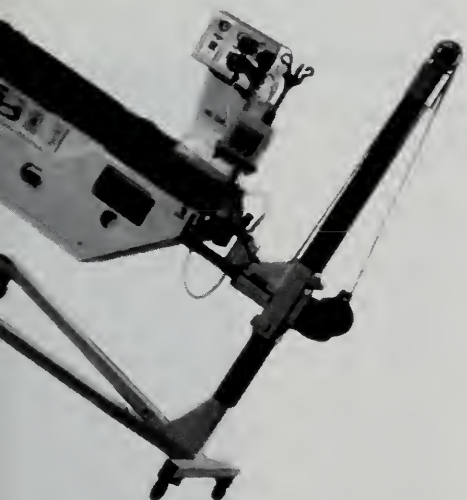
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Health Care Audits and Investigations

Act Now to Avoid Trouble Later

Medicare rules are confusing, and billing errors can lead to audits and investigations. Here's how you can minimize your risk of being accused of fraud.

David M. Glaser, J.D.

Physician billing practices are under increasing scrutiny. The number of FBI agents devoted exclusively to examining health care fraud has tripled in the last three years as agents who had been tracking suspected Soviet agents now focus on billing irregularities. The oversight does not stop with the government. Under the False Claims Act, disgruntled employees, competitors, and even patients have a financial incentive to seek out billing problems and file suit on the government's behalf.

A Medicare audit can be a very unpleasant experience, even for providers who believe they are coding and billing appropriately. Medicare has many complex and even irrational rules. On some occasions, Medicare will use one of these rules to recoup money even when physicians have provided competent, medically necessary services. Moreover, unless there is clear evidence in the medical record justifying the code used for a medical service, Medicare auditors may conclude that an overpayment has been made.

WHY SHOULD I WORRY?

The government has potent weapons to address billing and documentation problems. First, a provider may face criminal penalties for any willful disregard of the Medicare/Medicaid billing rules. While criminal penalties are certainly quite troubling, the government's ability to seek civil penalties is equally worrisome and per-

haps more surprising. While criminal penalties apply only if providers consciously attempt to defraud the program, civil penalties may apply to simple billing errors. For example, some clinics may systematically code exams as 99213 outpatient visits, which require about 15 minutes of contact with a physician and an expanded focused history or expanded focused exam. However, Medicare may believe that the documentation only supports about 10 minutes of physician contact time and a more routine focused history or exam, in which case, it may assess penalties of \$5,000 to \$10,000 *per claim*, in addition to a fine three times the size of the improper payments.

Under the False Claims Act, any individual who knows that an improper claim has been submitted to the government can file suit against the provider on the government's behalf. These actions are called *qui tam* suits and, in a successful case, allow the individual to keep up to 30 percent of the government's recovery. This creates a powerful inducement for disgruntled employees, competitors, or anyone else who believes a provider has made a billing error to file suit. *Qui tam* suits are becoming more common. For example, 125 well-known U.S. medical centers are currently involved in a *qui tam* suit claiming they improperly billed for procedures involving experimental devices. Defending against such suits can be costly and time-consuming.

RECOGNIZE THE WARNING SIGNS

There are often warning signs that a provider may become the subject of a major Medicare investigation. First, an investigator will usually send a letter requesting the release of medical records. Before releasing any records, providers should review the records for any patterns. If providers have any doubts about the documentation or the coding of the services, they should seek the advice of a lawyer or coding consultant immediately.

An assessment of an overpayment is another harbinger of trouble. The first recoupment is often extremely small, involving only a few thousand dollars or less. Often the amount is so small that the provider is inclined to pay it rather than contest the assessment or contact a lawyer. A year or two after the overpayment is assessed, the carrier might audit the provider, focusing on issues related to the overpayment. (Sometimes this audit occurs without the provider's knowledge.) If the audit reveals any similar problems, the carrier often considers referring the case to the U.S. attorney's office for possible criminal investigation or civil monetary penalties.

CONTACT YOUR LAWYER

Upon receipt of a Medicare overpayment letter—even one alleging a very small overpayment—contact a lawyer. The amount involved may seem

too small to justify a legal expense, but almost all clients involved in a major investigation wish they had called their lawyer a little earlier in the process. Depending on the circumstances, the call may be quite short, but at the very least, providers should confirm that their understanding of the billing rules is correct. They may also want to consider whether fighting the overpayment may nip future problems in the bud.

CONSIDER FIGHTING OVERPAYMENTS

Fighting an overpayment is easier (and cheaper) than one might think. After receiving a letter alleging overpayment exceeding \$100, providers have six months to file an appeal. Surprisingly, filing an appeal does *not* postpone repayment obligation.

Unless providers repay the overpayment within 30 days, the amount accrues interest at a relatively high rate.

Providers who appeal may choose one of three types of hearings: an "on the record" hearing, where a hearing officer simply reviews written documentation; a telephone hearing; or an in-person hearing. For any large sum, telephone or in-person hearings may be preferable because they allow providers to respond to the hearing officer's concerns. These hearings are quite informal, and the carrier often does not send a representative. Providers may choose to use a lawyer or may represent themselves. For those who choose to represent themselves, it is advisable to consult briefly with a lawyer first to confirm understanding of the billing rules. A decision on the hearing should be made within

30 days. If more than \$500 is in dispute, providers have the right to seek further review by an administrative law judge.

DON'T GET A FALSE SENSE OF SECURITY

Do not let investigative audits that find only a few improper claims give you a false sense of security. One of our clients challenged an overpayment involving about a dozen patients. The hearing officer ruled that the vast majority of the bills were correct, but three contained errors. Understandably, the provider viewed this hearing as a victory: the client won on 75 percent of the disputed claims. Apparently, however, the carrier disagreed. The carrier concluded that if it audited enough claims, it was likely to detect several

DEALING WITH AN INVESTIGATOR

At some point in your practice, you will likely have contact with a government investigator, whether that individual is investigating you, a colleague, staff member, or patient. As soon as you are aware of an investigation, call a lawyer. You will want to review your rights, including whether you must talk to the investigator, and consider the strengths and risks of each course of action. You also may be able to protect some information by invoking a privilege. (Patient confidentiality, peer review, the Fifth Amendment "right to remain silent," as well as the attorney/client and other similar privileges may apply to some information.) Once privileged information is released, it is likely that the privilege has been lost forever.

Here are the basic steps for dealing with an investigator:

- Verify the agent's credentials. Get a business card or a copy of the ID for each person present.
- Remember, an agent's strongest weapon is your fear—or your confidence. Either can prompt you to talk. Your strongest weapon is a polite silence. Silence can be awkward, and agents expect that you will attempt to fill the silence by explaining your

position. You may, under some circumstances, decide that your strongest defense is to explain your case to the agents. That is a big decision, and it generally should not be made during the first day of the investigation.

- In general, a government agent cannot require anyone to submit to any type of interview. (There are a few exceptions to this rule. For example, licensing agencies, such as the medical or nursing boards, place licensees in a Catch-22 because the professional is required to cooperate with the board to retain his or her license.)
- In general, an employer *cannot* forbid employees from speaking with an agent. If you attempt to prevent employees from speaking with the government, you may be charged with obstructing justice. However, it is perfectly legal for you to inform employees of their rights. Your legal counsel should provide you with a memo to every employee, outlining the following points:
 - a. Every employee has a right to choose whether to speak with the agent. The employer may not prevent an interview, and the agent may not require one.
 - b. If employees choose to submit to an interview,

more incorrect claims. Remember, with penalties of up to \$10,000 *per claim*, if the carrier finds 10 claims, the penalties can be \$100,000. Although the government is usually reasonable in selecting which cases to prosecute, it may pursue a case involving only a handful of claims if it so chooses.

BE PROACTIVE

LOOK FOR PATTERNS

Providers may be able to detect potential problems before an audit if they know what types of claims are most frequently rejected or sent back for additional documentation. Look for patterns. Billing personnel should do an informal survey of which types of claims are rejected and should attempt to determine whether rejections are more frequent for particu-

lar procedures or practitioners. A monthly meeting to discuss claim rejections may be an excellent use of time.

CONDUCT ROUTINE BILLING AUDITS

Although it is expensive to hire a consultant to perform an audit, the cost of a few improper claims will dwarf the audit expenses. Routine audits may also demonstrate intent to comply with the rules. Prosecutors recognize that the billing rules are complex. If providers make a good faith effort to comply, they are much less likely to face dramatic penalties for any mistakes.

DEVELOP A COMPLIANCE PROGRAM

Compliance programs can help detect trouble and reduce penalties should the government ever discover billing problems (see "The ABCs of

Physician Billing Compliance Plans," page 48).

DON'T ASSUME COMMON SENSE WILL PREVAIL

Many billing rules are extremely counter-intuitive. For example, many services provided by nonphysician personnel are billed using the physician's number because the service is considered "incident to" a physician's service. Many of our clients have been surprised to discover that the services they rendered did not meet the very strict rules governing "incident to" services. For example, one rule says that only services rendered by a W-2 employee of the physician can be considered "incident to" the physician's services. Services rendered by a consulting nurse, physician assistant, physical thera-

they have a right to insist on any conditions. For example, they may have an attorney present. (In some situations, the company may be required to provide an employee with his or her own attorney at company expense.) The employee may also insist that a friend or colleague be present for the interview.

c. Every employee should be told to tell the truth. Lying to a government agent is a crime.

d. No one should ever attempt to destroy documents or hide evidence during an investigation. Employees may believe that these acts help the provider or the employees. In fact, such conduct is a crime and damages the credibility of everyone involved.

- It is common for agents to contact people at home because the agents suspect people are more comfortable there and may feel less pressure from the employer.

- When an investigation begins, your first impulse may be to conclude that it is "all a misunderstanding" that could be cleared up with a meeting. Resist this impulse. Remember two key points:

- a. Because Medicare rules are so complicated,

you may have violated them without even knowing it.

- b. To many investigators, there is no such thing as an "innocent mistake." They see fraud where most of us would see only confusion.

- Never release any information to an investigator unless:

- a. The agent has a warrant; or

- b. You have consulted with a lawyer.

If you improperly release information, you may be violating patient confidentiality laws. Moreover, some of the information may be privileged.

- Keep a record of all information you release to the government, and keep notes of every conversation. After any contact with the government, you should call your lawyer and repeat every detail you can recall. It is also wise to dictate a memo to your attorney, clearly marked "attorney/client privilege; confidential," recording the facts. That memo, and any other privileged information, should be kept in a separate, locked file to which only management personal have regular access.

-DMG


pist, or other nonphysician who is an independent contractor cannot be billed under the physician's provider number. In these situations, the carrier may attempt to collect an overpayment even though legitimate, useful services were provided to the patient. While common sense might lead providers to believe that the carrier will not try to collect a refund for medically necessary services, most carriers believe that their contract requires them to apply the billing rules, not common sense.

In short, during the next few years, providers can expect to see a dramatic increase in the number of audits and investigations into health care entities. Now is the time for providers to try to reduce their chance of being a target.

MM


David Glaser is an attorney with Fredrikson & Byron, P.A., in Minneapolis.

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The ABCs of Physician Billing Compliance Plans

Follow these steps to develop a plan for complying with federal, state, and third-party payer billing requirements.

Gordon J. Apple, J.D., and Barbara Bowman

A corporate reimbursement compliance plan serves a multitude of practical and legal purposes for physician organizations. Foremost, a compliance plan provides a blueprint to assure that federal, state, and third-party billing requirements are being met. Following billing requirements is not only part of the contract that providers make with payers when they agree to see patients, but doing so also is necessary to avoid the negative consequences associated with accusations of negligent, abusive, or fraudulent billing.

COMPLIANCE PLANS— WHY THE FUSS?

The fuss behind reimbursement compliance plans has been generated by state and federal Medicare/Medicaid fraud units' increased enforcement activities, together with third-party payers' private fraud detection efforts. The federal and state government wield great power to enforce compliance. Just one example is the federal False Claims Act, which provides for penalties of \$5,000 to \$10,000 plus treble damages for each claim filed.

A number of potential problem areas in billing may affect physician practices. For example, teaching physicians need to meet the "physical presence" requirements when billing for the supervision of residents. Rural health care providers need to follow "incident to" rules that allow

providers to bill for the services of certain ancillary personnel. And everyone has heard of the prohibitions imposed by the Stark laws and regulations.

Questions abound: Do those "kickback" regulations apply to professional courtesy waiver of copays and deductibles? Is it OK to accept free computers from the labs physicians work with? What about upcoding or unbundling to get the reimbursement necessary to cover costs?

One way to begin answering these questions is through the development and implementation of a corporate compliance plan.

COMPLIANCE PLAN DEVELOPMENT

The first step in developing a compliance plan is to form a development team that will audit existing practices, develop the compliance plan, and oversee its implementation (see "The Compliance Plan Team," page 49, and "Inspector General Working on Model Compliance Plans," page 50). The development process begins with the Evaluation and Management (E&M) visit, during which the organization undergoes a systematic review to identify minor problems that can be easily corrected. For other, potentially more serious, problems, further testing is done, with the goal of formulating a plan of action.

THE E&M: WHAT TO EXPECT
The compliance plan E&M visit

should begin with a basic discussion of the process, and everyone involved should understand that the process may identify billing problems, perhaps some serious. The potential range of findings includes:

- No problems with billing practices.
- Mistakes that will require changes in practice and a minimal refund of overpayments not typically viewed as serious by the carrier corporate integrity office.
- Mistakes that will require changes in practice, the discipline of employees, and a refund of overpayments that will hurt the bottom line and may be viewed as more serious by the carrier corporate integrity office.

• Mistakes bordering on "fraud and abuse" that will require a substantial refund of overpayments. In this case, serious practice changes will need to be implemented and employees disciplined.

• Conduct clearly in violation of reimbursement program laws and regulations. Substantial overpayments will need to be returned, and fines may be imposed and employees discharged.

PRE-PLAN AUDIT OF PRESENT PRACTICES

The first concrete step in developing a compliance plan is the pre-plan audit of present billing practices. This process includes but is not limited to the following steps:

- review current billing policies

and procedures;

- interview medical and administrative staff;
- create a flow chart of current billing practices, from delivery of patient care to receipt of third-party reimbursement;
- identify glitches or potential problem areas for intensive review;
- audit sample charts;
- develop a summary of positions and practices that should be included in the plan; and
- identify financial and legal risks.

The product of the initial audit is a report that gives a detailed legal and financial analysis of any problems uncovered, sets forth options for action, and lists any process changes and training that will be required.

The auditors should present the report at a meeting where all parties have the opportunity to review the findings and agree on a course of action. At this stage, the audit has either discovered a sound billing process, possibly in need of some minor changes, or it has discovered serious

billing problems that will require obtaining professional advice because of the potential for significant financial and legal consequences.

SEEKING A CONSULT

When the audit turns up billing problems, such as repeated filing of false claims or unbundling of services, providers need to ascertain the dimensions of the problem. Corrective action may be necessary. The action plan may entail a variety of options, including, but not limited to:

- notifying various internal and external parties what has happened;
- determining loss to payers and returning money; and
- if necessary, disciplining employees.

It is critical that physicians who uncover billing fraud or abuse be able to demonstrate later that potential problems were promptly investigated and remedied once discovered.

DRAFTING THE COMPLIANCE PLAN

Based on the recommendations de-

veloped through the pre-plan audit and any follow-up consultations, the next step in formulating a compliance plan is drafting the plan itself. Common elements of compliance plans include:

- Standards of conduct—a mission statement that says the organization is committed to complying with billing guidelines and regulations, providing continuing education, monitoring its practices, and investigating and remedying any violations that are brought to its attention.
- Job descriptions—written statements setting forth each employee's responsibility for complying with billing requirements.
- Roles of physicians and staff—an outline of each person's responsibility in the billing process. For example, physician documentation and supervisory requirements should be addressed.
- Reporting mechanisms—a plan for how the organization will report billing problems that may be uncov-

THE COMPLIANCE PLAN TEAM: WHY AN ATTORNEY?

To design a corporate reimbursement compliance plan, an organization must form a development team. Generally, the team should include an attorney who is familiar with reimbursement program laws and regulations, a billing consultant, physicians from the organization, and representatives from the organization's internal business office and finance office.

An attorney should be involved for several reasons. First, the umbrella of the attorney-client privilege provides an environment where open and frank analysis and discussions can take place about issues and options. The attorney-client privilege protects from disclosure information that the client shares with the attorney in the course of obtaining legal advice. Second, numerous conflicts of interest may arise if the compliance plan process is directed internally. For example, the billing supervisor who knows that serious mistakes have been made under his watch may attempt to guide the audit to avoid

disclosure. A physician who has overzealously coded may be concerned about how her income will be affected.

To obtain the attorney-client privilege when formulating a compliance plan, several key requirements must be met. Initially, there has to be a mandate to conduct a legal investigation for the purpose of obtaining legal advice. Second, investigative work should be conducted at the direction of counsel, and any consultants who are retained should be hired through counsel. If in-house counsel are used, they must be able to demonstrate that they are acting in a legal rather than a business capacity to maintain the privilege.

Organizations that develop and implement a compliance plan without an attorney should be aware that every document addressing potential problems and every conversation about what to do may be subject to discovery by outside parties in the event of future litigation.

—GJA and BB

INSPECTOR GENERAL WORKING ON MODEL COMPLIANCE PLANS

The Department of Health and Human Services Office of Inspector General is working on developing a set of model corporate compliance plans for health care providers to use in an effort to show their compliance with Medicare and Medicaid laws, according to Inspector General June Gibbs Brown.

Brown said she hopes to have the first plans ready in draft form soon and expects to solicit public comment on them. The plans will not be published in the *Federal Register*, but most likely will be publicized through the press and national health care associations.

Brown said the plans will be tailored for the various health care industries. "We want to reach the large portion of legitimate operations and improve them," she said.

In comments during a press conference, Brown noted that compliance plans are now part of the settlement process. Many health care companies are putting their "best practices" into the plans to show their efforts to comply with Medicare and Medicaid fraud and abuse laws and billing procedures. Brown said she is concerned that some providers are paying large amounts of money to consulting companies to develop corporate compliance plans that may not contain elements the IG believes are necessary or beneficial.

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To address this concern, authors GJA and BB suggest providers require consulting companies to modify pre-existing plans to add IG elements, if needed, without charge, rather than delay compliance plan development and implementation.

ered through employee reports or internal audits. For example, the plan would designate to whom internal reports are made, how reports are handled internally, and how reports are made to third parties.

- Whistleblower outlet—a clear statement of the rights and protections afforded to employees who disclose problems.

- Disciplinary action—a policy to indicate that negligent, abusive, and/or fraudulent billing will be punished.

COMPLIANCE PLAN IMPLEMENTATION

Once a written plan has been developed and approved, the overall program is ready for implementation. This stage consists of training and certifying all parties involved in the billing process. Each individual involved needs to understand the reasons for and the elements of the compliance plan, as well as organizational expectations and standards of conduct.

Training can be done by outside consultants or by internal trainers who have been instructed in the appropriate legal and financial aspects of billing. The training sessions should present the standards of conduct, performance expectations, and responsibilities. Training should be specific to the audience. For example, physicians and others in a supervisory capacity have much greater responsibility for what goes on in the business office than a billing clerk.

Training does not stop with the initial sessions. Annual refresher programs should be mandatory elements of any compliance plan.

AUDIT AND REVIEW PROCESS

For a compliance plan to be effective, the organization must have a continuing commitment to monitoring, improving, and reviewing the plan. As problem areas are identified, the compliance plan may need to be redesigned and training implemented. The organization should undergo an E&M visit at least annually. Preferably, outside auditors will identify both the successes and shortfalls of the plan.

SUMMARY

As it evolves, an organization's compliance plan will become an effective risk-management tool. As the price for noncompliance becomes ever higher, the development and implementation of a corporate compliance plan makes both common and fiscal sense. A compliance plan should not be a program that is rolled out and then allowed to sit on the shelf and gather dust. The only thing worse than not having a compliance plan is having one and not following it. **MM**

Gordon Apple is an attorney in private practice. He is chair of the Health Law Section of the Minnesota State Bar Association. Apple formerly served as general counsel to Ramsey Clinic Associates and St. Paul-Ramsey Medical Center. Barbara Bowman is president of Medical Advisors, Inc., a medical consulting company specializing in physician coding, documentation, and third-party reimbursement.

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The Darker Side of Sports

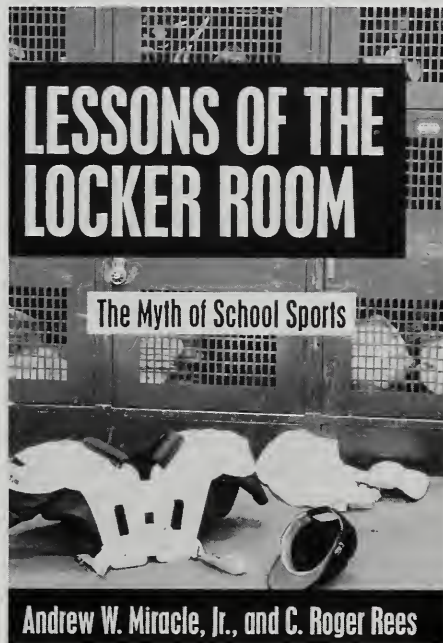
"Lessons of the Locker Room: The Myth of School Sports," by Andrew W. Miracle Jr. and C. Roger Rees (Prometheus Books, 1994), disputes the credo that sports builds character.

Reviewed by Charles R. Meyer, M.D.

Truths become clichés when oft-repeated. "Sports is big business" qualifies. Why American society has allowed it to become a cliché is an unsettling question. Where does sports fit in our societal psyche? What does it do for us collectively and what does it do to us? Whether sports builds character or insidiously molds destructive, dysfunctional behavior is explored in Miracle and Rees' book, "Lessons of the Locker Room."

Miracle and Rees bypass an analysis of sports empires and look at the breeding grounds for future stars—the schools. Here is where attitudes are crafted, where society shows its values. The authors start with the "sports builds character" credo, investigate its history, test its accuracy, and reveal its hypocrisy. They find winning—not fostering dedication—is the holy grail for school sports.

The seed of the sports builds character myth started in British private schools, where the cult of "muscular Christianity" reigned, and athletics was considered a mode of social control that taught participants to play by the rules. It was a society that emphasized toughness over kindness, firmness over imagination, certainty over intellect, and harshness over sympathy. It was "Darwinism misrepresented as survival of the most belligerent rather than the most adaptable." It was a society dominated by young men with domination as their goal.



Born in English schools, the myth traveled the Atlantic and found expression in the U.S. playground movement of the late 19th century. Seen as vaccination against the corrupting influence of urbanization on family life and values, playgrounds were supposed to be organized, adult-supervised activity that taught cooperation, subordination of self, and group loyalty. Concurrent with the playground movement and led by some of the same people, the Public School Athletic League organized the New York City schools. Standings and institutional competition transformed the playground ethic. The ideals of fairness, the value of group striving, and the merit of effort were

gradually subverted by the importance of outcome. "Fighting the good fight" was supplanted by success as the ultimate good.

Miracle and Rees trace these roots to present-day school sports. Their portrait of communities obsessed with the exploits of their high school teams is all too familiar to any parent or teacher trying to schedule a non-sports event during the state high school hockey tournament. The authors do acknowledge sports' beneficial role in community bonding: "Sports have been called the coin of social interaction. Sports are the common idiom that links Americans, whether friends or strangers."

But do these links depend on winning? Are better bonds created on winning teams? Would this bonding occur without the aspect of competition? At the very least, perspective has been lost: "When the victory of adolescents in sport becomes the principal, if not the only, measure of community worth, then the 'sport-builds-character' myth has been blown out of proportion," write the authors. This lack of perspective can sap a community's educational resources and divert attention from the primary goal of schools.

"Lessons of the Locker Room" also explores the darker side of the sports myth. In an unsettling variant of Lord Acton's statement about power corrupting, Miracle and Rees argue that power, strength, and success in sports can lead to aberrant behavior. Delinquency, alcohol use,

and sexual aggressiveness are tied to sports success in many of the studies cited in this book. The authors question whether athletes arrested for rape and drug use are only aberrancies or, rather, inevitable products of a philosophy that is dysfunctional at its core: "Feelings of superiority, elit-

ism, and the importance of general macho behavior are part of the modern self-image of male athletes," they write. This contaminates intersexual relationships as "these feelings of superiority may lead athletes to engage in promiscuity or the abuse of women."

How accurate is all this? Miracle and Rees' argument has some holes; for instance, they don't fully examine the growing prominence of women's athletics. How does the macho, character-building myth translate to women participating in sports? This is not clear from their analysis, but evidence exists that "in-your-face" aggressiveness by girls is prevalent on the playground and on the court.

"Lessons of the Locker Room" is disturbing and provokes speculation: How many of the men involved in today's epidemic of domestic abuse are frustrated athletes who had their egos decimated by lack of success on the gridiron? Farfetched? Think about the culture of your high school or our kids' schools. What is valued, what is rewarded? Will we raise another generation of macho Lombardi advocates for whom "winning is everything," or will we help shape kids who know the value of effort, the worth of others, and the definition of real success? These are lessons that can be learned in the classroom, the dining room, or the locker room.

MM

Charles Meyer is editor-in-chief of Minnesota Medicine and an internist with Consultants-Internal Medicine in Minneapolis.

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People and Places Making Medical News

People

Diabetes Center Executive Director

Richard M. Bergenstal, M.D., is the new executive director of the International Diabetes Center (IDC), part of the Institute for Research and Education Health-System Minnesota. Previously, he was an endocrinologist with Park Nicollet Clinic and senior vice president for Diabetes Care at IDC. He succeeds IDC founder **Donnell D. Etzwiler, M.D.**, a pediatric diabetologist at Park Nicollet Clinic, who will be named president emeritus when he retires in 1997.

ACP Awards

B.J. Kennedy, M.D., and **Alvin L. Schultz, M.D.**, both of Minneapolis, are among 31 fellows of the American College of Physicians named masters in a convocation ceremony held in April at the ACP 77th Annual Session. Mastership is the highest level of membership attainable in the ACP, a society of physicians trained in internal medicine and related subspecialties. ACP fellows are nominated for mastership by an awards committee and elected by the ACP Board of Regents. They are chosen for their personal character, positions of honor or influence, contributions toward furthering the purposes of the ACP, and/or eminence in practice or medical research.

Kennedy is emeritus regents' professor of medicine, emeritus masonic professor of oncology, and past director of the division of oncology at the University of Minnesota Medical School. Schultz is a former executive officer of the Medical Affairs Division of HealthSpan Corp. and a former chief of medicine at Hennepin County Medical Center.

Leonard T. Kurland, M.D., of Rochester, was given the James D.

Bruce Memorial Award for distinguished contributions in preventive medicine. Kurland is senior consultant and professor of epidemiology in the Department of Health Sciences Research at Mayo Clinic. He has had an international influence on epidemiology and neurology.

Foundation HealthSystem Minnesota Board

The Foundation HealthSystem Minnesota has elected three new members to serve on its board of directors: **Greg Rye**, president and chief executive officer of Arnold & Rye Printing, Ink.; **Carol Johnson**, superintendent of St. Louis Park Schools; and **Richard Struthers**, president of IAI Mutual Funds.

Places

Andersen Schools Opening On-Site Clinic

The three Andersen Schools in south Minneapolis have joined forces with local health plans and hospitals to offer a range of health services to students. The services, which will be provided by a nurse practitioner, medical case manager, health educator, family outreach worker, and other support staff, are intended to help keep kids in school. The three elementary schools have among the highest absentee rates in Minneapolis, primarily because students fail to receive needed health care. One in six Andersen students have asthma, and the students have a high rate of hospitalization and emergency care.

The majority of students are insured through Medicaid. Four health plans that enroll Medicaid patients, Allina (Medica Health Plan), HealthPartners, Metropolitan Health Plan, and UCare

Minnesota, have agreed to pool resources to support the new health services. Each health plan is paying \$20,000 for start-up costs, and Allina's Abbott Northwestern Hospital, which is located near the schools, is providing a \$40,000 community outreach grant to help cover the initial costs of the nurse practitioner. To support ongoing costs, each health plan will contribute funds proportional to the number of students enrolled in that health plan.

The success of the services will be scientifically measured and compared. Anticipated outcomes for students include better health, less absenteeism, and lower health care costs resulting from fewer visits to the emergency department or hospital.

Health System Minnesota, St. Louis Park Schools Opening Clinic

HealthSystem Minnesota and the St. Louis Park school system have opened a free school-based clinic at Central Community Center in St. Louis Park for children through age 18. The clinic, staffed by HealthSystem Minnesota volunteers, is open Wednesday afternoons through the summer and will add Thursday afternoons starting September 17. In addition, it will provide 24-hour telephone care coverage and referrals. Care at the clinic will include preventive services, health education, and counseling.

"This is one of the first, if not the first, health programs in the west metro suburbs that recognizes the problems associated with being poor in the suburbs," said HealthSystem Minnesota spokesperson Carol Hobart in a Twin Cities *Star Tribune* article. The clinic will not ask for evidence of insurance coverage.

HealthSystem Minnesota's foundation contributed \$50,000 to

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the clinic, the school system donated the space, and Kraus-Anderson Construction provided free materials and labor to convert the space to a clinic.

Socioeconomics

St. Paul City Council Considering Health Department Merger

As *Minnesota Medicine* goes to press, the St. Paul City Council is considering a controversial proposal to merge the St. Paul and Ramsey County public health programs. The proposal calls for transferring \$9.3 million in city programs to Ramsey County. The county would assume responsibility for health policy decisions and would take over the city's health department building at 555 Cedar Street. The city would maintain a voice in service-level changes.

Proponents of the merger, including St. Paul Mayor Norm Coleman, say it would improve coordination and flexibility and save city homeowners about \$10 a

year per household. Opponents fear it would jeopardize the city department's mostly low-income clientele.

"I don't believe [the proposal] goes far enough in prioritizing the key services that should be protected," said Keith Henry, M.D., director of HIV/AIDS Clinic and Programs at St. Paul-Ramsey Medical Center, in a *St. Paul Pioneer Press* article. "I am concerned that the suburban Ramsey County residents may ... not be willing to continue funding services that are principally located in the city of St. Paul."

Baxter, Value Health Offering Drug Management Services

Chicago-based Baxter International, Inc., and Connecticut-based Value Health, Inc., are forming a joint venture to be based in Plymouth, Minnesota, to provide drug management services to hospitals. Value Rx, a prescription drug management subsidiary of Value Health, located in Plymouth, will provide many of the employees and some of the information services that will be used to help hospitals prevent medication errors and control drug costs. The company will sell its services to hospitals, nursing homes, and other institutions that provide medications to patients.

Rates, Trends, Data

Growth in National Health Care Spending Slows

U.S. spending on health care grew more slowly in 1994 than any year since 1960, according to the Office of National Health Statistics of the Health Care Financing Administration. Health care spending totaled \$949.4 billion, or 13.7 percent of gross domestic product, a growth of 6.4 percent for 1994. Indicators for 1995 suggest a continuing trend.

Government officials attribute the slower growth to greater use of managed care and the looming

possibility of federal action to control health care costs.

Law & Policy

Supreme Court Upholds Access to Data in State Tobacco Suit

The U.S. Supreme Court in late May upheld a lower court decision granting Minnesota and other states involved in tobacco lawsuits access to five tobacco companies' and two trade groups' computerized indexes of internal industry memos, research papers, and other documents. The computer data will help the Minnesota attorney general and Blue Cross and Blue Shield of Minnesota, co-plaintiffs in the state's lawsuit against the tobacco industry, sort through millions of industry documents.

Minnesota's lawsuit, which seeks reimbursement for treatment of smoking-related illness, charges that tobacco companies have for years illegally deceived the public about the dangers of smoking and manipulated nicotine in cigarettes to hook smokers.

Earlier in May, lawyers for Minnesota's lawsuit discovered research documents from R.J. Reynolds that attributed 1970s sales of a competitor's product, Philip Morris' Marlboro cigarettes, to "deliberate and controlled" nicotine enhancing methods. A Reynolds memo on file recommends that the company develop cigarettes with additional nicotine "kick" aimed at the youth market.

Innovations

Spine-Tech Wins FDA Approval for New Device

Edina-based Spine-Tech Inc. has won FDA approval, with certain conditions, for its spinal fusion device. The BAK Interbody Fusion System, which is placed in the spine opening after a disc is removed, is designed to allow bone to grow around and through the device to help support the spine. It is designed for use in patients with mild disease who otherwise wouldn't



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have any type of internal stabilization of the spine after surgery. About 230,000 people undergo spinal fusion each year.

The FDA said the company's BAK Interbody Fusion System should be used only for patients who suffer from low back pain for more than six months. The FDA also required the company to continue monitoring the device's success in patients for up to five years.

'U' Surgeons Perform Bowel Transplant

University of Minnesota surgeons transplanted the intestines of a Florida man, a suicide victim, into a 33-year-old Minnesotan suffering from Crohn disease. Although a number of these transplants have been done worldwide, it is the first time University of Minnesota surgeons have performed such a transplant since immunosuppression drugs were developed in the early 1970s; earlier, in 1967, the late Richard Lillehei, M.D., attempted the surgery, but the patient died of complications after 48 hours. As *Minnesota Medicine* goes to press, the recent patient remains in stable condition.

The patient, from Jordan, Minnesota, was diagnosed with Crohn disease at age 13 and has been on the transplant waiting list since he developed life-threatening complications 10 months before the surgery, which was performed by Rainer Gruessner, M.D. Because the procedure is considered experimental in adults, the University of Minnesota Hospital and Clinic paid for it. The cost can range from \$80,000 to \$250,000.

Medical Research

Diet, Exercise, Drugs Best Defense Against Mild Hypertension

Lifestyle improvements, along with a low dose of an antihypertensive drug, can significantly lower blood pressure and improve cholesterol levels in people with mildly high blood pressure, according to

Minnesota research published in the May 21 *Journal of the American Medical Association*. University of Minnesota Medical School Professor Richard H. Grimm Jr., M.D., Ph.D., and colleagues

monitored 902 men and women aged 45 to 69 years with stage-one hypertension. The participants showed no clinical evidence of coronary heart disease. They were recruited from 11,914 persons

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screened for the Treatment of Mild Hypertension Study (TOMHS) at four U.S. academic clinical research units.

"In TOMHS, nutritional-hygienic intervention resulted in significant blood pressure lowering and favorable long-term effects on all major lipid fractions," wrote the researchers. "When this intervention was combined with a low-dose antihypertensive drug regimen, enhanced blood pressure reduction also resulted."

The participants were checked for blood pressure and blood lipid levels, including total cholesterol, high-density lipoprotein cholesterol, low-density lipoprotein cholesterol, and triglycerides. They received intensive lifestyle counseling to help them lose weight, increase physical activity, and cut back on salt and alcohol intake. The participants were also randomly selected to receive either placebo

or one of five antihypertensive drugs: 1) beta blocker, 2) calcium channel blocker, 3) diuretic, 4) alpha-one antagonist, or 5) angiotensin-converting enzyme (ACE) inhibitor.

The researchers found that after four years of follow-up, participants lost an average of 7.9 pounds, reported an increase of leisure-time physical activity of 73 percent, and reduced alcohol intake to about one drink per week. As a result, blood pressure was significantly reduced. The average decrease in blood pressure was 15.9/12.3 mm Hg for participants combining lifestyle changes with antihypertensive agents. The average decrease for those with lifestyle changes and no antihypertensive agent was 8.6/8.6 mm Hg. In addition, the regimen decreased total cholesterol, LDL cholesterol, and triglycerides, while increasing HDL cholesterol.

High-Dose Chemotherapy Best Option for Some Leukemia Patients

Patients with an aggressive form of leukemia who do not have a suitable family member to donate bone marrow for a transplant have a higher survival rate if they receive high-dose chemotherapy than they would if they underwent a transplant using their own bone marrow purged of cancer cells, according to a new study by the Children's Cancer Group. The results were reported in May by William G. Woods, M.D., professor and director, Pediatric Hematology-Oncology Division, University of Minnesota Cancer Center, at the American Society of Clinical Oncology annual meeting in Philadelphia.

The study confirmed that allogeneic bone marrow transplantation, which uses marrow donated by a matched sibling or parent, is the best treatment option for children with acute myelogenous leukemia who have achieved remission. In the absence of a

matched family donor, physicians have been uncertain about the best way to treat patients who have achieved remission. Only 30 percent of patients have a suitable family match. The study showed high-dose chemotherapy has a 10 percent higher disease-free survival rate three years after remission than autologous bone marrow transplantation.

The randomized trial included 450 children with acute myelogenous leukemia in remission to determine the optimum form of post-remission therapy. The patients were treated with allogeneic bone marrow transplant if possible, or were randomly selected to receive autologous BMT with purging versus chemotherapy using high-dose cytarabine and other drugs.

Overall survival three years from the end of remission was 76 percent for the 140 patients receiving allogeneic BMT; 59 percent for the 160 patients receiving high-dose chemotherapy; and 45 percent for the 150 patients treated with autologous BMT. Disease-free survival rates for three years post-remission were 70 percent for the allogeneic BMT group; 50 percent for the high-dose chemotherapy group; and 40 percent for the autologous BMT group. The study also found that radiation treatment did not significantly improve outcomes in BMT, an important consideration for children because radiation treatment can increase the risk of secondary cancer and other long-term side effects, such as developmental problems.

Anesthesia Care Teams Provide Safest, Most Cost-Effective Outcomes

Administration of anesthesia by a team of professionals led by an anesthesiologist working with a nurse anesthetist or anesthesiologist's assistant is the safest and most cost-effective method of delivering anesthesia care, accord-

ing to Minnesota research published in the June issue of *Anesthesia & Analgesia*. The conclusions, reported by J.P. Abenstein, M.D., and Mark A. Warner, M.D., of the Mayo Clinic in Rochester, were drawn from a 1995 Minnesota Department of Health study called for in the 1994 MinnesotaCare legislation.

The authors contend that anesthesia care teams combine their knowledge, skills, and observations to make the most appropriate care decisions. "This team model is identical to models used to care for patients in intensive care units. When a problem occurs with an individual patient in either of these settings, more than one physician and more than one nurse or other provider are rapidly available to assist with the care of that patient. This may be the key to improved patient outcomes," said Abenstein.

Public policy decisions should encourage the development of anesthesia care teams where none exist, particularly in rural areas, the authors recommend.

Exposure to Pesticides May Increase Risk of Birth Defects

Exposure to pesticides and fungicides may increase the risk of birth defects among people living in agricultural regions of Minnesota, according to a University of Minnesota study. Researchers compared statewide birth records between 1989 and 1992 with a list of nearly 35,000 farmers licensed to use pesticides. Birth defects were significantly higher among the 4,935 children born to those farmers compared with the general population. Some defects occurred two to three times more often. In addition, birth defects are generally more common in agricultural areas than in urban and forest areas, raising the possibility that indirect exposure to pesticides and fungicides, possibly through drinking water, increases the risk of birth defects.

The study, published in *Environmental Health Perspectives* magazine, found that birth defects in agricultural areas are noticeably higher for infants conceived in the spring, when herbicide use is at its peak. And the defects occur far more frequently among male babies of pesticide applicators than among female babies.

The lead researcher in the study, Vincent Garry, M.D., director of environmental medicine and pathology at the University of Minnesota, said it's not certain whether pesticides caused the defects. He called circumstantial data linking exposure to some of the 12 herbicides he studied suspicious, but said in a Twin Cities *Star Tribune* article, "There's sufficient data here to warrant a real close look at what's going on."

Increased Access to Physicians May Not Improve Health

Increasing a severely ill patient's access to a primary care doctor may not improve the patient's well-being, according to a study conducted at nine Veterans Affairs medical centers and reported in the May 30 *New England Journal of Medicine*. Patients in the study who were given greater access to a physician were sent to the hospital far more often and spent more days there than similarly ill patients. In addition, 25 percent more of these patients died during the first six months after hospitalization, although this may not be statistically significant. The researchers theorized that greater access to physicians led to more diagnoses and treatments.

Researchers were surprised by the results. "We went into the study trying to see if increasing access to outpatient care after discharge [from the hospital] would decrease admissions," said Morris Weinberger, Ph.D., chief author of the report and director of health services research at the Roudebush Veterans Affairs Medical Center in Indianapolis,

Indiana. "We found we increased it—by 36 percent. Now we are trying to find out why," he said in a Twin Cities *Star Tribune* article.

The study included 1,396 patients severely ill with diabetes, congestive heart failure, or chronic obstructive pulmonary disease. Of the 695 randomly assigned to extra care, 59 died. Of the 701 who received conventional care, 47 died; the difference is not statistically significant.

However, the study found that patients who received extra medical attention were more satisfied with their care than the patients who received conventional care.

Cellular Phones Disrupt Pacemakers

Digital cellular phones can disrupt the functioning of pacemakers when used by patients with the implants. In the first large-scale study of the subject, researchers

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from Mayo Clinic and elsewhere found that the phones can, for example, change the pace of the device or shut it off. The study did not determine if the disruptions threaten patients' health or life; tests were stopped if the researchers suspected a potential for problems.

The disruptions occurred in 53 percent of the 975 pacemaker patients tested and were more common when a phone's antenna rested directly over the pacemaker and rarely when the phone was held to the patient's ear.

Phones using North American Digital Cellular technology, the type most commonly available in the United States, caused interference in 28 percent of the tests.

Analog phones caused interference in just 3.1 percent of the tests.

Ticks Can Spread More than Lyme Disease

Deer ticks common in Minnesota and Wisconsin may simultaneously

transmit Lyme disease and other serious infections, according to a report by researchers from the Mayo Clinic and elsewhere published in the June 5 *Journal of the American Medical Association*.

In Minnesota and northern Wisconsin, infection is likely to include ehrlichiosis and babesiosis, which might explain why some people experience more severe cases of Lyme disease following a deer tick bite. Babesiosis suppresses the immune system, making it difficult for the body to resist the spread of Lyme disease. The researchers found that the number of symptoms and duration of illness in patients with both Lyme disease and babesiosis are greater than in patients with either infection alone.

Doctors should use doxycycline to treat patients diagnosed with Lyme disease because the antibiotic fights all three types of bacteria, said David Persing, M.D., Ph.D., director of Mayo Clinic's microbiology laboratory in Rochester. **MM**

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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

AUGUST 1996

Aug. 2-3 **Bleeding and Thrombosing Diseases: The Basics and Beyond** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Aug. 8-10 **Third Annual Symposium on Biomedical, Biopharmaceutical, and Clinical Applications of Capillary Electrophoresis** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Aug. 16-17 **Point-of-Care Testing and Phlebotomy** Mayo Medical Laboratories; Swissôtel, Boston, MA. CONTACT: Julie McAdams, Mayo Medical Laboratories, Hilton 360, Rochester, MN 55905; 800/533-1710.

Aug. 18-20 **Success With Failure: New Strategies for the Evaluation and Treatment of Congestive Heart Failure** Mayo Foundation; Vail Cascade Hotel & Club, Vail, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Aug. 24 **Phacoemulsification Course** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Aug. 24-27 **International Symposium on Radioiodine** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

SEPTEMBER 1996

Sept. 9-10 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Sept. 12-14 **Practical Surgical Pathology Conference in Honor of Louis H. Weiland, M.D.** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Kathy

Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, Rochester, MN 55905; 800/533-1710.

Sept. 19-20 **Mayo Clinic Update in Hepatology and Liver Transplantation** Mayo Foundation; Hotel Sofitel, Minneapolis, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 19-20 **Sixth Annual Practical Pediatrics Course for the Primary Care Physician** Children's Health Care; Children's Health Care-St. Paul, MN. CONTACT: Mickey Starr, 345 North Smith Avenue, St. Paul, MN 55102; 612/220-6133.

Sept. 19-21 **Echocardiography for the Sonographer 1996: Focus on Myocardial and Valvular Disease** Mayo Clinic; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 21 **Current Concepts in Glaucoma** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Sept. 26-27 **Twenty-third Mayo Clinic Pediatric Days** Mayo Clinic; Radisson Plaza Hotel, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

Printed Material: **Physicians' Update: Bloodborne Pathogens** Medical Education Group Learning Systems. CONTACT: MEGLS, Internet address: <http://www.cme.edu> or call 800/547-0308.

Sept. 29-Oct. 4 **Advances in Diagnostic Radiology and Advanced Radiology Life Support** Mayo Foundation; The Broadmoor Resort, Colorado Springs, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

OCTOBER 1996

Oct. 3-5 **Mayo Vascular Symposium 1996: Advances and Controversies in the Multidisciplinary Management of Vascular Disease** Mayo Clinic and North American Chapter of the International Union of Angiology; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Oct. 4 **Insights and Outlooks '96** St. Paul Heart Clinic; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440; 612/992-3826.

Oct. 6-11 **Laboratory Diagnosis of Fungal Infections** Mayo Medical Laboratories; Portland Marriott at Sable Oaks, South Portland, ME. CONTACT: Kathy Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Oct. 11 **Ophthalmic Plastics Course** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 11-12 **Advanced Life Support in Obstetrics** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 12 **Twentieth Annual Current Trends in Ophthalmology Symposium** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 14-16 **1996 International Meeting on ANCA and ANCA-Related Diseases** Mayo Clinic and Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Kay Kenitz, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-8399.

Oct. 23-24 **Duluth Diabetes Conference** Duluth Clinic; Duluth, MN. CONTACT: Rockie Odberg, Medical Education Coordinator, 400 East Third Street, Fifth Avenue Building, Duluth, MN 55805.

NOVEMBER 1996

Nov. 4-5 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Nov. 9 **Minnesota Society of Pathologists Annual Fall Anatomic Pathology Conference With Steve Silverberg, M.D.** Minnesota Society of Pathologists; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Jennifer Nelson, MSP, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Nov. 14-16 **Mayo Clinic Ob/Gyn Clinical Reviews** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

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Family Practice, Ob/Gyn to join progressive 14-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*2/96-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

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Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

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Internal Medicine: The Fergus Falls Medical Group's five-member Internal Medicine Department is seeking a BC/BE general internal medicine physician as well as those with subspecialty training/interest in oncology, pulmonology, and nephrology. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (9/95-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine (oncology, pulmonology, and nephrology), family practice, ophthalmology, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (2/96-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

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Family Practice Opportunity on north shore—Lake Superior. Primary Care Clinic. Focus: wholeness, prevention, and education. Contact Jon Ward, Bay Area Health Center, 50 Outer Drive, Silver Bay, MN 55614; 218/226-4431. 3-8/96

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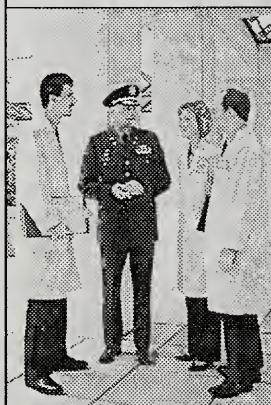
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*1-7/96

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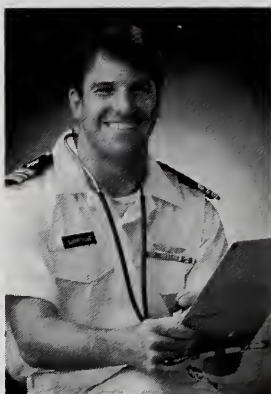
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• Highlights of AMA Annual Meeting • Viewpoint: What is the future of medical education?



Media Hype: Searching for Substance

News media—the public institution we all love to hate. Anti-press vituperation crosses political, social, economic, and ethnic boundaries. Charges of misrepresentation, bias, and sensationalism by the press date back to Jefferson's time. How accurate is the criticism of today's journalists and how does it affect coverage of medical science? Two recent books, "Breaking the News: How the Media Undermine American Democracy" by James Fallows (Pantheon Books, 1996) and "Selling Science" by Dorothy Nelkin (W.H. Freeman, 1995), dissect current media practices and produce remarkably similar postmortems.

Fallows, an editor for *The Atlantic Monthly*, ranges widely and sometimes tangentially in his critique of the American news media. He decries sportification, celebrityfication, and sensationalization of the news. Sportification casts every issue in sports terms, to the detriment of the issue. An article on welfare reform is 90 percent "What are the chances for a Democratic win?" and 10 percent "What is welfare reform?" Celebrityfication is the glorification of reporters (usually TV) to the status of celebrities with seven-figure salaries and \$50,000 speaking fees. The media have elevated the talk show, where glibness and sound bites rule, to a cultural and political force. Larry King has replaced the press conference. Sensationalization picks the glitzy, the gaudy, and the gory over the germane.

A press like this, says Fallows, distorts public perceptions of issues that are crucial for the health of our democracy. It perpetuates a reading or watching public that cries for more entertainment and less education.

Topics appealing to emotion discourage thoughtful, reasoned discourse about what matters in our society.

Science reporting is different, you say? Not according to Dorothy Nelkin, a professor in the sociology and law departments at New York University. Nelkin echoes Fallows' themes. Sports: "Science in the press becomes a form of sport, a 'race' between scientists in different disciplines or between competitive nations, a rush to the 'publication finish line.'" Sensationalism: "Reporting on biotechnology, the press bats readers back and forth from biotechnology miracles to visions of apocalypse, from celebrations of progress to warnings of peril, from optimism to doubt." Celebrities: Although few science reporters could claim the notoriety of a Sam Donaldson or a Ted Koppel, Nelkin argues, the pronouncements of a Dr. Tim Johnson on NBC carry disproportionate weight with the viewing public.

These dysfunctions of the press draw us further from a thoughtful approach to our world. For scientific and non-scientific topics, the press shapes public perception and expectations. For politicians, a cynical press produces a cynical public that expects dishonesty and duplicity from their public servants. For scientific medicine, a sensational press leads to miracle-expecting patients. The latest political scandal starts the politician's phone ringing. The latest "breakthrough" jams doctors' switchboards.

The media retorts, "We give the people what they want. Our readers and viewers want their science and politics star-studded, sexy, and short." Both Nelkin and Fallows would ask, "Who's leading and who's following?" Children fed Snickers from birth have little taste for Brus-

sels sprouts, and a public glutted with simplistic sensationalism will not beg for complex discourse in the media. Looking for what your audience thinks is relevant can be an excuse for reinforcing skewed views.

Nelkin and Fallows urge journalists to pursue a depth of reporting rarely seen in current publications. Fallows extols "public" or "civic" journalism, a concept promoted by NYU professor Jay Rosen, who envisions a journalism that "invites people to become a public," that "fashion(s) a coherent response to the deepening troubles in our civic climate." Civic journalism needn't be dull. Both Nelkin and Fallows want reporting that entertains while it informs.

How our media talk about the world and science is important. Journalists have the daunting task of quickly learning about multifarious issues, which they then translate to teach their readership. Thomas Jefferson said: "The man who reads nothing at all is better educated than the man who reads just newspapers." Journalists need to take this wise man's critique to heart and enhance their role as educators. We need more cerebration and less celebration. The media need to understand that a coherent, realistic grasp of our health care and our democracy is a truly sensational story worthy of their pursuit.

MM

Media Watch is an occasional column written by Minnesota Medicine's editor-in-chief, Charles R. Meyer, M.D., an internist with Consultants-Internal Medicine in Minneapolis.



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Charles R. Meyer, M.D.

I've a feeling we're not in Kansas anymore.

—Dorothy, "The Wizard of Oz"

Some days it seems like the Minnesota medical scene is inhabited by tin men and scarecrows—baffling creatures that point both ways on our path. Although anger and frustration are common emotions heard in doctors' lounges, perplexity is more common: "What's happening here? What's going on with our professional lives?" Daily, docs feel like a dazed Dorothy thrashing through fields of poppies, experiencing a sense of unreality. No wonder droves of physicians have sought safe haven through acquisition by hospital or health plan organization. Whether such employment is the Emerald City for Minnesota physicians is the focus of this month's *Minnesota Medicine*.

As noted in Howard Bell's cover story (page 14), the reasons physicians choose employment are as numerous as the differential diagnoses of cough; they're seeking job security, a steady flow of patients, access to big-system resources, and lifestyle changes. In return, physicians relinquish decision-making autonomy in the business side of their practices. Whether clinical autonomy is also compromised is a question unanswered by our articles. Clearly, the trade has not worked for everyone, as evidenced by the disconsolate employed physicians interviewed by Bell.

Minnesota's 1,700+ employed physicians are the tip of a national iceberg where proprietary firms like Mullikin have merged with Caremark to form multibillion dollar companies employing more than 7,000 physicians. This avalanche of contracts prompts questions for phy-



"It's not surprising that the instability of today's medical climate should drive physicians to the apparent sanctuary of a corporate womb."

sicians and for health organizations.

For the organizations, the probing question is: "Now that you've got these physicians, what are you going to do with them?" The PR departments reply: "integrate them" or "make them a system" or "realize economies of scale." For most organizations, I would contend, such goals are about as concrete as Dorothy's rainbow. A corollary question is, "Does corporate management philosophy work in a small doctor's office, or do health care organizations try to hammer unwieldy corporate solutions into a previously smoothly running clinic operation?" Claims of decremental costs and incremental quality through fundamental management are, so far, either excremental braggadocio or elemental pipe dreams.

For physicians, the issue comes

to this: "Do you know what you're buying?" Physicians have traditionally been a risk-averse bunch. Thus, it's not surprising that the instability of today's medical climate should drive them to the apparent sanctuary of a corporate womb. Most of the employed physicians in Bell's article say their practices have changed little and any incentives have had minimal effect on their practice patterns. But, if true, will that persist even in the face of corporate red ink? In his article "Selling Your Practice to a Provider System" (page 21), David Hoffman advises physicians to know the corporate culture before making a deal. Yet the culture of a multi-billion dollar company is hard to grasp, and a deal between mice and elephants is rarely struck on a level field.

And what if you want a divorce? As Thomas Doyle says (page 27), it's not as easy as clicking the heels of your ruby slippers. Doyle's article makes it clear that buying back a practice is as inviting as meeting the Wicked Witch—without a pail of water.

No, it ain't Kansas, Dorothy. But like a Kansas twister, the delivery of health care in Minnesota is swirling in the air. Where and when it will come down and who will still be holding on is uncertain. Both health care organizations and physicians will need wizards to give them direction. For health plan organizations, black bottom lines and quality care will likely be the answer booming from the mysterious presence behind the curtain. For physicians, it all boils down to what you want out of your work and your career. Where is your yellow brick road?

MM

COVERING THE MEDICAL

MINNESOTA MEDICINE TAKES A GLIMPSE INSIDE THE TWIN CITIES
STAR TRIBUNE TO CHECK UP ON THE PAPER'S MEDICAL REPORTING TEAM.

Highly trained specialists with inside knowledge of a profession are certain to read news articles about their specialty with a critical eye. I have seen a politician throw his newspaper across the room in dismay when he read a reporter's summary of a public hearing, wondering aloud if the reporter had been in the same room with him or on another planet.

No one can blame physicians for sharing a similar skepticism of reporters. After all, if your profession requires six, eight, or 12 years of intense, demanding, and specialized training, how can someone with no medical background presume to analyze your chosen field of work?

And yet, at the largest newspaper in Minnesota—the Twin Cities *Star Tribune*—a health and science reporting team does just that every day. Between them, the editor and reporters on the team have a combined 53 years of experience writing about medical issues. And while that doesn't give them a license to practice, it does give them powerful influence in the medical community and with the general public.

Recently, I attended one of the team's weekly strategy meetings where they talk shop and discuss story ideas. As a reporter assigned to cover other reporters, and as someone who works with physicians, I expected to feel kinship with them as I entered the conference room on the third floor of the old *Star Tribune* building in Minneapolis. Instead, I felt the same unease I sometimes experience when interviewing physicians, and I realized that reporters and doctors actually have something in common: they hate being interviewed.

"We don't like it," says reporter Maura Lerner, eyeing my microphone with suspicion. "We're usually on the other side."

After agreeing to ground rules restricting my ability to use certain information (newspapers have embargoes just like medical journals), I settled into a chair next to Gordon Slovt, a 28-year veteran on the medical beat and arguably the most influential medical reporter in Minnesota. Known for his outstanding news judgment and accuracy, Slovt is revered by his colleagues. Everyone on the medical team has input on story ideas and coverage, but it is clear that Slovt's opinion holds sway.

While Slovt's place is secure among his colleagues, he still works hard to gain the confidence of physicians. Slovt covered the Legislature before becoming a medical reporter and says there are fundamental differences between using doctors and politicians as sources.

"You just can't jump on doctors for information," he says. "I spend a lot of time meeting with doctors in a setting where I'm not trying to get information out of them, letting them know who I am, so they can trust me."

Once he has won their trust, Slovt says physicians are better sources than politicians. "They aren't shooting the same angles; they aren't trying to trade with you. Politicians try to trade with you. You know, 'If you write about this, I'll do that.' I don't see doctors doing that at all."

Slovt is blunt about the greatest change he has

By Jeremiah Christopher Whitten

BEAT



PHOTOGRAPH BY ROB LEVINE

The Twin Cities *Star Tribune* health and science reporting team. Front: Gordon Slovit. Middle row: Maura Lerner, Joey McLeister, and Josephine Marcotty. Back row: Dan Wascoe, Susan Gilbert, Duane Braley, and Jim Dawson. Not pictured: Glenn Howatt and Jean Shea.

The *Star Tribune* Health and Science Team

Josephine Marcotty, team leader/editor

Joined the *Star Tribune* in 1979. Worked on the business section until September 1995, when she became health and science team leader.

Maura Lerner, reporter—medical issues

Has been writing about medicine since joining the *Star Tribune* in 1986. Principal *Star Tribune* reporter at the trial of John Najarian, M.D. Former reporter/producer for "MacNeil-Lehrer NewsHour."

Gordon Slovut, reporter—medical research

Twenty-eight year veteran of the medical beat. Widely respected by colleagues and physicians. Worked at *Duluth Herald* and *Duluth News Tribune* before coming to the *Star Tribune* in 1962. His son David is a sixth-year resident in cardiovascular surgery at the University of Minnesota.

Glenn Howatt, reporter—medical business

Worked at *CityBusiness* before joining the *Star Tribune* six years ago. Studied urban geography and worked as an information officer at the University of Illinois before switching to journalism.

Jim Dawson, science reporter

Came to the *Star Tribune* in 1979 as a general assignment reporter and has covered science issues for the past 10 years. Awarded fellowships at MIT to study science journalism and Woods Hole Marine Biological Laboratories to study neural systems.

Dan Wascoe, consumer health reporter

Started at the *Star Tribune* in 1967 covering metropolitan affairs, Hennepin County government, advertising, and business. Joined the health and science team two years ago.

Jean Shea, copy editor

Joined the health and science team in September 1995 after working at the *Argus Leader* in Sioux Falls, South Dakota.

Susan Gilbert, photo editor

Joined the *Star Tribune* in 1994 after stints at *New York Newsday*, *Miami Herald*, and *Rocky Mountain News* in Denver.

Joey McLeister, staff photographer

Primary photographer for the health and science team. Joined the *Star Tribune* nine years ago after working at the *Duluth News Tribune*.

Duane Braley, staff photographer

Back-up photographer for the health and science team. Joined the *Star Tribune* in 1962 following an internship with *National Geographic*.

seen in medicine in his time as a reporter. "Doctors aren't the boss anymore," he says. "You used to be able to figure that if the doctors didn't go along with something, it wasn't going to happen. But I don't know if they have that power anymore."

Physicians sometimes criticize newspapers' ability to convey medical information and put it into a meaningful perspective for a broad audience. Glenn Howatt, who covers medical business for the *Star Tribune*, says reporters have different goals than physicians do when covering medical stories.

"Our stories are not miniature versions of journal articles," Howatt says. "Our stories are about the release of some paper, or the event, and our job is to understand that. We look at the researcher and the institution who paid for the research and put it into context. It's not our job to rewrite what's in their article. We do more than that."

Josephine Marcotty, team leader and editor, agrees with Howatt and says that a reporter's mission is to take medical news and make it relevant to the average reader—something that a physician is not always interested in doing.

"We're looking for things that are significant even if you're not a doctor," she says. "An example is when medical researchers do a lot of research with rats, and then make a huge leap in terms of researching a particular disease or a treatment of a disease. Within the research community, that's incredibly significant. But it's not significant beyond that community, because it doesn't relate to people. We have to make it relevant to people who read our newspaper, which is a mass-market product. We're writing for everyday people, not medical researchers."

Because the team at the *Star Tribune* writes about medical issues for a lay audience, they do not see lack of medical training as an obstacle. In fact, Lerner says that a science or medical degree could inhibit a reporter. "I once heard someone say that the drawback if you come to science writing as a scientist is that you get the science right and the journalism wrong, and if you come in with a journalism background, you get the journalism right and the science wrong," she says. "So you have to compensate no matter where you come from."

Lerner believes a well-trained reporter should approach a medical story the same as she would any other story. All good stories have the same basic elements.

"I'm looking for the same thing [in a medical story], and that is, 'What do people care about in this

issue?' There are the 'insiders,' who will only care about it as an 'inside baseball' story, and then there are the rest of us who care about it for broader reasons."

Dan Wascoe, consumer health reporter, agrees that the basic elements of a story are universal, but adds that a reporter has to keep his audience in mind. Wascoe, who wrote for the newspaper's business section for 10 years, says the paper's audience is segmented.

"In the business section, you know who your readers are. They're a narrowly targeted segment of the total audience. But in consumer health issues, there is a much broader audience. Not everyone owns stock in a company, but everyone is concerned about their health. Readership on health issues is much broader in terms of gender, age, occupation, and education."

Experience is the key to good medical reporting, according to science reporter Jim Dawson. "There is a lot of bad science and medical reporting in the world," he says. "You read a lot of bad medical stories by the general assignment reporter from the Associat-

ed Press who's suddenly thrown into the AIDS debate and doesn't know what he's talking about. I think the whole point is to try to get people who specialize in [medical reporting], are trained in it, and understand the context before they go into these stories. People who have done it for some time understand the nuances, understand what questions to ask."

Dawson says it is also important to be willing to go back to a source and ask for help, even on deadline. "If you're writing and suddenly realize you don't understand exactly what you're saying, the most dangerous thing is to try to bluff your way through it," he says. "You'll be wrong every time. And so, then, you call them back and say, 'OK, this is how I'm phrasing this. Is this correct?'"

Many physicians ask to review a reporter's story before it is published, which reporters are loath to do for anyone. Dawson makes an exception for medical and scientific accuracy, but that's where he draws the line.

"I'll read sections back," Dawson says, "especially the paragraphs where I'm explaining the science or the

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medical procedure. [But I] almost never read [sources] back quotes because they'll start changing things. They'll say, 'Oh, gee, did I say that? Well, it sounds better if I say it this way.' You don't read them back the whole story, because when they hear it back, they want to change it to make themselves sound better or more eloquent."

Lerner agrees that reporters can't give sources a chance to edit their own copy. "It always carries the risk that they're going to want to rewrite history or make themselves sound better, or take back things they said that may have been in the heat of the moment. Maybe they regret it, or maybe they were too candid before and now they're trying to put it back in the can."

Lerner smiles, however, and admits that this impulse is human nature. "There isn't anything wrong with doctors wanting to do this," she says. "We'd probably do it with your story if you gave us the opportunity."

Physicians also complain that reporters make too many mistakes and take things out of context when

rushing to meet deadlines. But Marcotty defends her team's record. "A lot of people who are not in the news business are stunned at the speed with which we do things," she says, "and people make a lot of cracks about newspapers being inaccurate, but, in fact, given the circumstances under which we do stories, we're remarkably accurate. On this team, our error rate is actually very low, because we know that our credibility depends on it."

"The [criticism] seems to imply that we take our daily deadline as a license to be reckless," says Lerner, "or a license to put in stuff that we don't know, and that's certainly not what we do. We know we have a deadline, but as far as being professionals, we're only going to put [into a story] what we're confident is right."

Many of the competitive pressures felt by the medical team at the *Star Tribune* come from other media with a different mission in their coverage.

"We compete with television," says Marcotty. "We compete with magazines like *Time* and *Newsweek*. If they make a big deal out of a story, we often

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have to, because people turn to us expecting to see it in our paper, and if we don't give it to them, then they'll stop buying our paper. But what we can do is make sense of it and give [readers] the depth and the information to put things into context."

Marcotty cited as an example a recent front-page story regarding digital cellular telephone signals that can disrupt the functioning of pacemakers.

"Do you know what television would have done with that? 'Your cell phone is dangerous!' " she proclaims in a doomsday voice, and then laughs. "End of story. But we were able to say, 'Yes, it can be a risk for people with pacemakers, and there was a scientific study that demonstrates how and why it's a risk, and this is the information you need to know in order to reduce that risk.' The way I like to look at it, we can be a voice of reason on medical stories."

Dawson is skeptical that television can cover medical stories with the right perspective. Dawson spoke recently on a panel along with a manager of a television station. "This guy kept going on and on about how all he wanted to know about science was

whether coffee was good for him or not," Dawson recalls. "He wanted a yes or no answer, and he wasn't going to get it. Ever. But that's how they think out there."

It was almost 5 p.m., and the reporters on the medical team were sneaking glances out the conference room window toward the newsroom. There were deadlines to meet and a newspaper to publish. I thanked them for their time, and felt pleased that I had gained their trust. As they hurried out of the room, Howatt looked back over his shoulder. "Send us your story before you publish it," he said with a laugh. "We'll go over it for you."

I thanked him. But, like any good reporter, I politely declined. MM

Jeremiah Christopher Whitten is a free-lance writer and a former anchor/reporter for public and commercial radio stations. He is also a media consultant to political campaigns and private and nonprofit businesses, including Gillette Children's Specialty Health-care in St. Paul.

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The Consultation

A patient's request to be referred for an abortion sends this physician into an ethical tailspin.

As a family physician, I recently consulted with a woman who desired referral for an abortion. The circumstances were difficult. She had a chronic disease and required ongoing medication, both of which she feared might harm the fetus. She was a single parent with one child and now, this pregnancy.

I left the room after hearing her story and called both an expert geneticist and my consulting perinatologist. They assured me that neither the patient's chronic disease nor her medication would jeopardize a healthy pregnancy. Returning to the room, I gently shared this knowledge. In the dialogue that followed, it became clear that, in reality, the patient had decided to have an abortion for reasons related to her life situation—she was a single parent trying to hold down a job and was concerned about her finances and facing her colleagues at work.



ILLUSTRATION BY JANE MJOJNESS

How does today's health care system respond to a woman who desires an abortion because of such difficulties? As a physician on the front lines, let me tell you: The response is largely procedural. A 10- to 15-minute appointment, usually with a busy physician, confirms the pregnancy. The woman's options—having an abortion or going through with the pregnancy—are described. Referral is given to a reproductive health care facility or physician's office that has the proper and safe instrumentation to perform abortion essentially on demand. Supportive counseling, no matter how compassionately given, is virtually limited to 1) determining what the woman really wants to do, and 2) making sure she has not been coerced. Many times, such questions are enough to change a woman's mind. **By James K. Struve, M.D.**

According to a physician I spoke with at a reproductive health care facility, one or two out of 10 women who seek an abortion leave without the procedure based on these considerations.

Outside this system are organizations, usually religiously affiliated, that offer prolife counseling to help women with unwanted pregnancies. Unfortunately, however, there is no communication between the medical facilities performing abortions and these usually nonprofit, small-budget, almost entirely volunteer organizations.

Is this the system society really wants? Is such care consistent with what we value or should value most? We must answer these questions as a nation and as physicians.

The Clinton administration reportedly believes that abortion should be legal, safe—and rare. The U.N. population conference has agreed that all efforts should be made to reduce abortion. Most Catholics, Muslims, and many Protestants view abortion as morally wrong. Most physicians view abortion as destructive work, not to be done for expediency; they consider it a procedure someone must do safely to preserve personal choice and to prevent back-alley disasters.^{1,2}

Reality in the United States differs from these viewpoints. Abortion is currently the most common surgical procedure in our country. Though legal and statistically safe, it is not rare. There are 354 abortions for every 1,000 live births in the United States. This ratio has remained almost constant since 1975.³ The present system supports abortion on demand—not abortion as a tragic option.

The present system of care for women with unwanted pregnancies is out of sync with certain cherished values. Too much weight is given to expediency and personal control—not enough to the value of self-sacrifice, communal sharing of hardship, and the value of suffering for another. I was called into medicine to value and preserve quality human life, regardless of a patient's age, economics, gender, or beliefs. All that separates the woman in my clinic from an abortion is a busy, pressured physician and a clinic that includes as "indications" for abortion financial hardship, emotional distress, failure to use contraception properly, less than ideal circumstances surrounding the pregnancy, and most singularly, the woman's desire to end the gestation.³ There is no link to pro-pregnancy counseling and education or social and financial support.

We need to reduce unwanted pregnancy and abortion, not simply by improving family planning, but also by changing the way women view pregnancy within the context of their lives. We need the equivalent of government-supported hospice care for women with unwanted pregnancies. Physicians who don't see abortion as morally wrong nevertheless need to cease performing abortions for expediency. The guilt of an abortion performed as an act of despair under circumstances of human and economic destitution lies within the community—not the individual. We, as a society and legislatively, need to place enormously high value on the completion of pregnancy and the necessary support. Clinics need to offer women with unwanted pregnancy community counseling and access to social resources. All faiths need to continue to expound on the value God places on life.

As it turned out, I told the woman I was unable to refer her for an abortion but told her that others could do that. I left the room but she didn't. The nurse told me the woman wanted to see me again. She was tearful. We talked about her religious upbringing and her past. I suggested we talk again the following week. She left and has not returned. I did not want to push, so I have not tried to contact her. I did give her the name of a pro-pregnancy counseling agency and told her not to make a decision that could cause her irreversible regret later.

The consultation stopped my day. I slipped an hour behind in my schedule. Patients fretted. The nurses became uneasy. I felt like a cog in the system. I felt something profound was happening and no one got it.

MM

James Struve has been in private family practice in Minneapolis for the past 21 years.

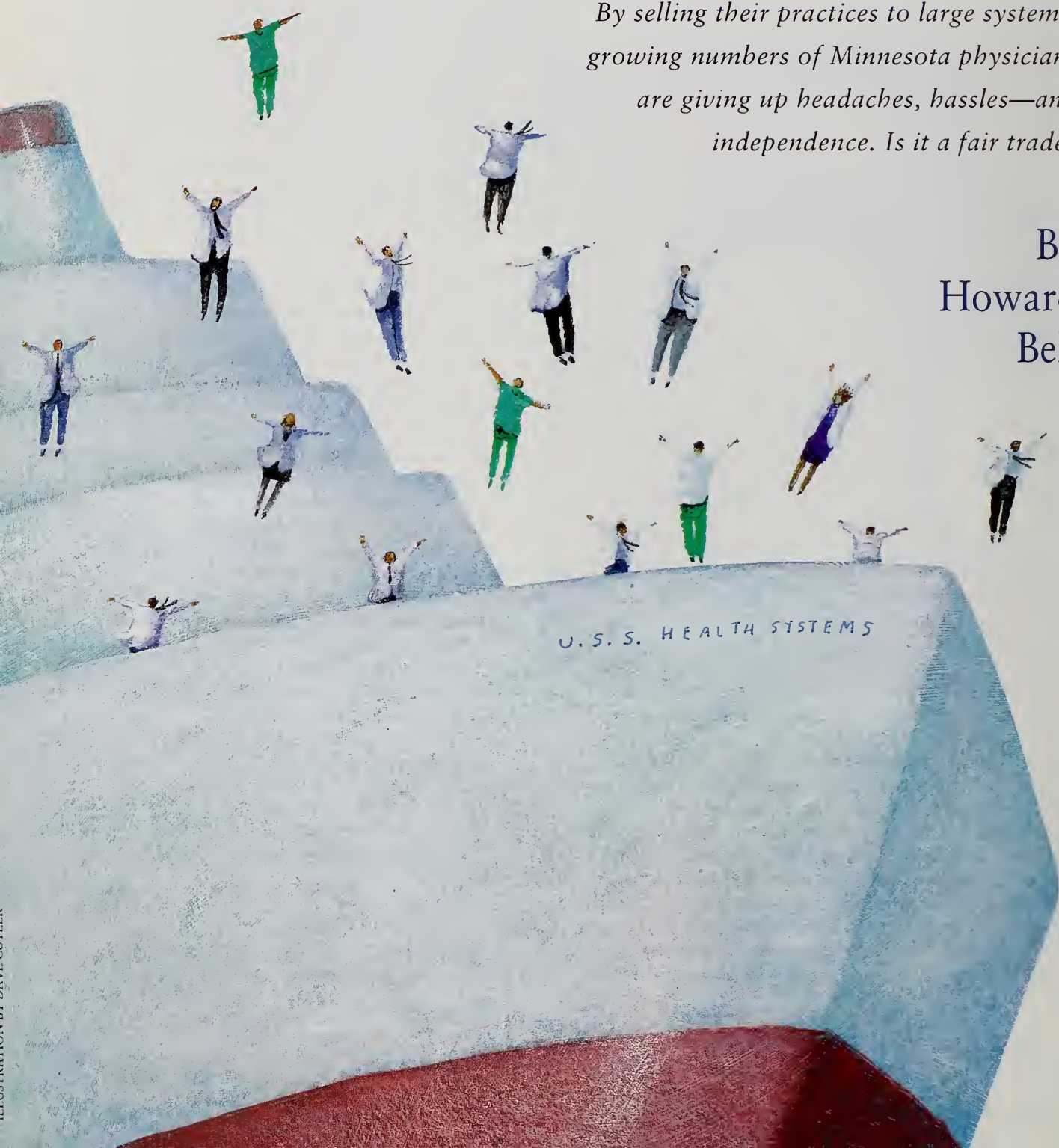
REFERENCES

1. Weisman CS, Wathanson CA, Teitelbaum MA, Chase GA, King TM. Abortion attitudes and performance among male and female obstetrician-gynecologists. *Fam Plann Perspect* 1986;18(2):67-73.
2. Westfall JM, Kallail KJ, Walling AD. Abortion attitudes and practices of family and general practice physicians. *J Fam Pract* 1991;33(1):47-51.
3. Lyon FA. Elective termination of pregnancy. *The Bulletin of Park Nicollet Medical Foundation* 1989;33(1):45-57.

Joining the Ranks of the Employed

*By selling their practices to large systems,
growing numbers of Minnesota physicians
are giving up headaches, hassles—and
independence. Is it a fair trade?*

By
Howard
Bell



Once upon a time, when Wayzata Internal Medicine had a decision to make, they'd order Chinese, gather in the conference room, and reach a decision before the last pea pod was plucked from the plate. Today, the Wayzata group is part of HealthSystem Minnesota. Many decisions are made a rung or two up the corporate ladder by the unknown, the unseen, and the seemingly unhurried. "Sure it's frustrating," says Bill Tiede, M.D., a physician with the practice, "but it's a small price to pay for what we got in return."

What the Wayzata partners got when they sold to HSM three years ago is job security, deeper pockets, and some immunity from losing patients with the stroke of a pen—the same benefits that have enticed hundreds of other Minnesota primary care physicians to leave independent practice and become employees of large systems.

Self-employed independent physicians used to be the standard. Now, because of buyout fever, fewer than half of the Twin Cities 2,400 primary care doctors remain independent, according to a recent Twin Cities *Star Tribune* survey. Forty percent are employed by Allina, HealthPartners, HealthSystem Minnesota, and Fairview. Five health systems own most Twin Cities hospitals and HMOs and one-third of the 500 Twin Cities primary care clinics.

When Wal-Mart Comes to Town

Physicians react to corporate medicine like villagers when Wal-Mart comes to town. Some see a good place to work and a cost-effective place to shop for health care. Others see the end of a way of life and long for the days of the corner doctor's office. Most physicians interviewed for this article agreed that opting to sell a practice is an appropriate, practical response to an increasingly integrated, cost-conscious health care system—but not necessarily the right choice for everyone.

Robert Dybvig, M.D., says if he and his partners at Cambridge Medical Center hadn't sold to Allina, they'd never have come up with the cash to build their new clinic. Physician recruitment is easier now, too. The physicians have reasonable call schedules, and their compensation package is generous. "We spend the same amount of time with patients and practice medicine the same way we always have," he says. "And we're not locked into referring to Allina hospitals."

Dybvig freely admits the clinic's physicians lost some decision-making independence. "We have control of about half of what we used to control. Clinic management is not entirely local anymore. Budget

targets are dictated by headquarters, and we pay into a corporate kitty to cover system-wide legal, medical records, and support services."

He also admits not all the partners are happy about it. "We gave up a degree of independence we treasured," he says. "Some of us feel disenfranchised with no say in the direction we're taking. It's especially hard for some of the older guys in the group to just see patients while someone else runs the business. But the tradeoff is worth it. We've lost a lot of headaches and overhead stressors. And we've got job security."

Physicians who sell to large systems tend to do so because they believe medicine has evolved in a direction that puts independent practices at a competitive disadvantage. They're concerned that as medicine becomes increasingly dominated by big integrated systems, their patients will go elsewhere unless the practice is part of a system. Some like the idea of banking the proceeds from selling their independent practice plus getting a guaranteed salary and a steady flow of patients. Some want out from under medicine's ever-growing business hassles so they have more time to practice medicine. In return for becoming part of a corporate fiefdom, physicians get access to the royal treasury: money to expand clinics and purchase equipment they could not afford as independents. The decision to sell is a blend of pragmatism seasoned with fear.

"We gave up a degree of independence we treasured.

But the tradeoff is worth it. We've lost a lot of headaches and overhead stressors. And we've got job security."

—ROBERT DYBVIG, M.D.

Though Gerald Mullin, M.D., has practiced independently for most of his 30 years as an internist, he believes the pluses of selling outweigh the minuses. Mullin and his partners at Nicollet Medical Group sold to Fairview Health System because they had trouble recruiting physicians and, like other independent practices, felt the squeeze between growing overhead and shrinking reimbursements. Now they conform to company policies on clinical pathways and protocols, whether preparing joints for injection or just recycling waste paper. They attend more meetings, too, as Fairview standardizes its operating procedures throughout its system. "It does bother me in a way," says Mullin, "because we used to just sit down

and decide to do something, and now decisions go through a chain of command. But it's worth putting up with."

Mullin says he and his partners save significantly on billing because it's now handled off-site. He's also pleased with Fairview's hands-off approach to his clinic's character. For example, Fairview uses financial incentives for physicians to see more patients but accepts the fact Mullin and his partners decided not to cut the time they spend with patients. "Patients like it that way," he says.

Buyouts are an appropriate response to the growth of managed care and integrated health care, according to Eugene Ollila, M.D., president of Hennepin Medical Society and an internist with Abbott Clinic, owned by Allina. "Medicine is now practiced by teams, which are easier to orchestrate through the scale and sophistication of large systems," he says.

"Did we give anything up—like our souls? I don't know," says Ollila, who has practiced medicine for 30 years. "This is the first time I've been an employee. It changes the feeling and sense of who you are, but it's not a bad change. Now we have the best of both worlds: a small group practice backed by large-system resources."

Teamwork scares some physicians, suggests Bill Spinelli, M.D., a family practitioner at Allina's River Valley Clinic in Hastings. "Some just don't work well in a team." Spinelli says most physicians in his group are content with Allina. They have income protection, access to support services, practice management tools, and expertise they would not otherwise have.

A St. Paul physician who did not want his name used said he and his partners sold to HealthEast for purely pragmatic reasons. "We did it because we didn't want to be on the losing side. The winning side is managed care."

His group experienced no bad side effects from the buyout. He believes HealthEast is a good model, and physicians are generally satisfied. The key, he says, is physician participation in governance. "When administration seeks physician input, you have a cooperative system you can live with."

Kenneth Sansome, M.D., practiced independently for 22 years before he and his partners at Family Physicians of Northfield merged with HealthSystem Minnesota. He says the rough spots they encountered were inevitable but have pretty much resolved now that a year has passed. They chose HSM for its strong physician leadership. The Northfield clinic's staff has grown, and they have access to Blue Plus patients.

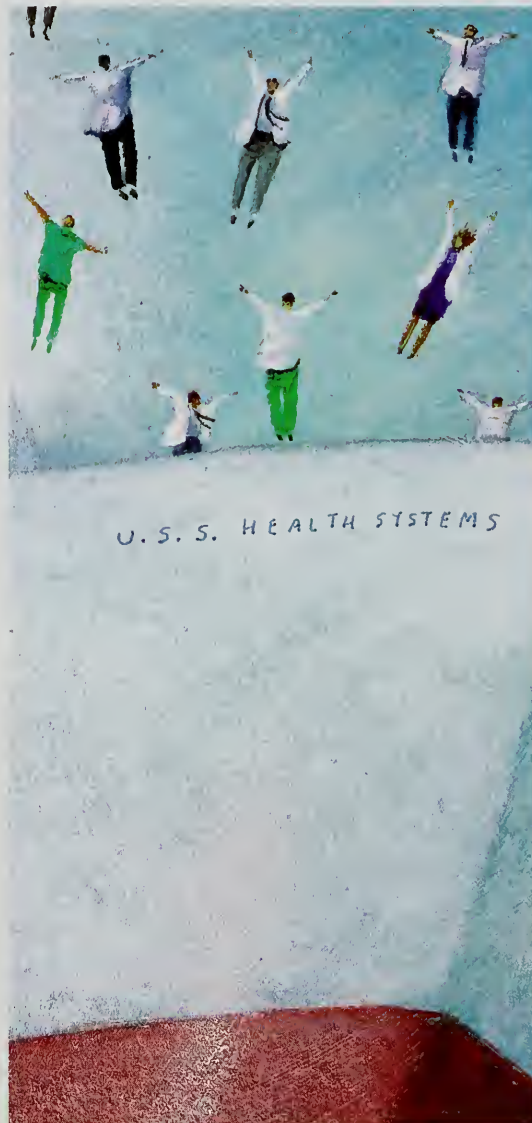
Family Physicians merged with HSM after the partners concluded they could not survive for the long

term as an independent practice. The physicians wanted relief from time-consuming office management hassles, too. Sansome says HSM liked how the group practiced medicine, and their practice style has not changed. He and his partners still micromanage their office. "We didn't want anyone telling us where to put the phones."

Back-Room Grumbling

It's easy for satisfied physicians to say so. But what about the dissatisfied? Though most physicians say they generally like their new status as employees, many admit they are aware of back-room grumbling. One former HMO employee who wished not to be named says it's hard to get the truth from physicians who have crossed over from independence. They're scared of losing their jobs, he says, or being black-balled as dissidents or troublemakers.

Grumbling is widespread, if the number of physicians who declined to comment for this article is any indication. Some feared legal and job security prob-



lems if they went on record as being less than happy as a formerly independent. One affiliated group declined to comment because they are leaving their large Twin Cities system, unhappy for reasons they cannot discuss until their departure is legally resolved. Meanwhile, an independent group is going the other direction, but they plan to bypass local systems and sell to a national system. They promised the buyer not to comment publicly until the deal goes through.

One physician who gave up independent practice to become an HMO employee left disillusioned. He fears legal retaliation from his former employer if he goes on record. He says his HMO experience was "indescribably stressful and an absolute nightmare," and argues that loss of independence subtly affects medical judgment.

"It happens, but it's not written anywhere, and no one's telling you pointblank to limit tests and cut corners." This physician found it hard to maintain the same energy and enthusiasm he'd felt as an independent physician because he was never rewarded by the HMO for practicing good medicine. "We received no credit for paying attention to details or for high patient satisfaction. Physicians are supposed to listen to the patient and not just prescribe after a couple of minutes," he says. "We're supposed to integrate lab reports and other findings and come up with a reasonable treatment. When you're an independent, that's what brings people back."

"How can any physician who cares about the patient be happy in a system where the bottom line is the sole measure of success?" asks this disgruntled doctor. "They'll never admit to this and there's no paper trail to incriminate them, but what [employers] want is doctors who will shut up and work as hard, for as long, for as little as possible."

"The doctors' lounge is the worst place to be," says Jim Rusin, M.D., an Anoka family practitioner. "A roomful of doctors moaning and groaning. Big players are sucking up the system. There's no place to go. People need to ask the hard questions, like why must doctors be owned?"

Change is stressful, agrees Dybvig of Cambridge. "There's a lot of grumbling behind the scenes. Some [physicians] feel it's too much change too fast. Others prefer the status quo. I see the change as an improvement."

The house-call days of independent fee-for-service medicine are amusingly antiquated compared with the Orwellian picture of corporate medicine detractors paint. Some resent an assembly-line care system, where insurance companies move large numbers of patients to market and physicians must posi-

tion themselves to treat their share—where employed physicians toil like widget fixers, caring for strangers they may never see again, their medical judgment compromised by contracts, bonuses, patient quotas, and clinical pathways. Others complain of more subjective problems: a lost sense of community, an impersonal, detached approach to medicine. Still others sigh and say medical practice just isn't like it used to be.

The Stillwater Medical Group believes it has preserved a sense of the good old days by remaining independent. "We believe we have a greater closeness to the community," says Bill Spillseth, M.D., a senior physician with the group. "Independent practice is our core value. Not only can we shape our practice to meet community needs, we control our own schedules and how much time we spend with patients. Stillwater has experienced no problem recruiting physicians. There is a place for independent practice, especially in outlying communities."

For Spillseth and his partners, independence has not meant being cut off from the benefits of large-system affiliation. "We retain autonomy and benefit from relationships with big players," says Spillseth. "They add value to our clinic like quality assurance ideas, treatment benchmarks, and good cost data."

Ramsey Medical Society President Ken Crabb, M.D., offers a similar assessment. "I have a personal need to control my own destiny. Remaining small and independent does not preclude having relationships with others. Fear is the primary motivation in these buyouts, but the threat is overblown," says Crabb, an ob/gyn with the three-physician Advanced Specialty Care For Women in St. Paul.

Risky Business

Fear may contribute, but there are practical reasons for becoming an employed physician. The risks of independent practice have become greater than many physicians are willing to take, according to Jim Hart, M.D., deputy medical director of St. Paul-Ramsey Medical Center. "Practicing medicine today takes more business management expertise and risk taking than it used to. There was a time when money flowed freely and you could be a little sloppy running a practice."

Hart says physicians as a group are by nature averse to risk. Buyouts make sense when you couple this aversion with an abundant supply of physicians, a reduction in the revenue flowing into the system, and the opportunity for older physicians to cash out in return for guaranteed income.

Most complaints Hart hears from employed physicians concern finances and operations, not clinical

practices. "It's frustrating to operate within rigid budgets not of your own making and go through a bunch of layers just to hire a nurse. I see a fair number of physicians who feel trapped in these big systems," says Hart. "They see things that need changing, but they are helpless to change them. Passivity develops. They throw in the towel. 'I'm just an employee,' they say. 'I went into this as a profession, not to punch a time clock.'"

Preserving the Status Quo

It is possible for independent physicians to be happy as employees, but the change can be difficult, according to Perry Hanson, co-founder of Minneapolis-based Partners Consulting Group, Ltd., which helps physician practices respond to health system changes brought on by managed care pressures.

Becoming part of a large system does not necessarily mean a physician loses the spirit of entrepreneurial practice, he says. The trick is to make the relationship a merger, not an acquisition. But successful mergers are rare. All too often it's an acquisition, where the system's rules, policies, compensation structure, mission, vision, and values control the physicians. "People who are acquired have few rights," says Hanson. In a merger, two entities combine resources. The

physician has input and influence.

Hanson advises physicians to negotiate up-front "preservation of the status quo." Too many physicians sell their practices out of fear and without evaluating what they need to be professionally satisfied. Physicians need to have a clear business plan in mind, he says. "You need to know the costs and benefits of selling, and you need to know what is most important to you. Only then will your interests be represented in the final agreement." (See related articles, pages 21 and 27.)

To be satisfied employees, Hanson says, most physicians need compensation that recognizes their productivity, some control over their work schedules, and some control over quality and clinical outcomes, which includes a degree of freedom to practice in their own style. "Typically, physicians lose some or all of this during negotiations," he says. "By default, they end up practicing as the organization desires, with the result that both the organization and the physician are worse off."

Tiede, of Wayzata Internal Medicine, believes in the power of pre-sale negotiations. "We have a very satisfactory relationship with HSM because we negotiated up front a situation we could all live with."

Sansone is a believer, too. His family practice group in Northfield, now part of HSM, learned the ins and outs of "the new medicine" so well that when it came time to align, they knew what they wanted. "We chose [HSM] as much as they chose us. We share similar practice philosophies. You've got to have clear reasons why you're [selling]. It can't be a knee-jerk fear response. Expect problems and keep your road map out."

Big Twin Cities systems differ in how they operate and how they view physicians. As Hanson puts it, they have a range of attitudes toward physicians, who must compare the differences and try to find a good match for their needs. "It's the physicians' problem and responsibility," says Hanson. "They're selling a piece of their lives, so they better be committed." **MM**

Howard Bell is a free-lance writer living in Onalaska, Wisconsin.

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Selling Your Practice to a Provider System

A Practical Guide for Making Your Decision

Physician practices are increasingly prime targets for acquisitions by large health systems. Should you consider selling, here's advice to help ensure an enduring relationship.

David C. Hoffman, Ph.D.

Astute health care executives understand that organizationally integrated and geographically dispersed primary care physician networks are key to health system success in managed care markets. Thus, large multispecialty medical group practices, hospital systems, health care plans, and insurers have been building networks and snapping up physician practices—primarily family medicine, general internal medicine, and pediatric groups—at a dramatic rate. In the last year, hospital-based systems reported a 60 percent increase in practice acquisitions.¹ This article outlines the key factors you should consider if you are interested in selling your practice to a large provider organization, such as a regional physician group or hospital system.

WHAT HAPPENS WHEN YOU SELL YOUR PRACTICE?

Regardless of who approaches you about buying your practice, you must be able to answer a number of fundamental questions to make a wise and informed decision. The reality is that when you sell your practice, it is no longer yours. In most cases, you become an employee of the acquiring entity—either a group practice, a hospital system, an insurance group, or health plan. You are asked to sign an employment agreement, and it is the system, not you, that ultimately makes final decisions regarding compensation, vacation,

and location of the practice. While not necessarily a bleak prospect, life will be different, and you should have a thorough understanding of what awaits you.

WHY DO YOU WANT TO SELL?

The first question you should ask is, “Why do I want to sell my practice in the first place?” The answer varies depending on your age, career stage, and individual financial circumstances. The reasons for selling range from hoping to catch the market at the right time and cash-in at an opportune moment, to ridding yourself of the hassles related to managing a practice—the growing bureaucracy of daily practice management. Older physicians view practice sales much differently than those who have recently entered practice. Physicians nearing retirement generally focus on the economics of a purchase offer, while those with many years of practice ahead tend to be more concerned about long-term professional compatibility with other physicians and the acquiring system.

The reasons for selling usually fall into the following categories:

- the economics of the sale;
- the opportunity to position the practice for managed care contracting and reimbursement;
- the opportunity to access capital for practice growth; and
- the desire to be part of a larger group.

ARE YOU AND THE BUYER COMPATIBLE?

Selling a practice can be compared to a marriage. Most physicians hope for a happy, enduring relationship once the ceremony (in this case, the sale) is over. To help ensure a satisfying professional life following the sale, physicians must carefully consider the financial and market viability of the acquiring entity, the professional culture and environmental fit, physician-to-physician collegiality, and “professional investment potential”—the buyer’s ability to provide long-term professional opportunities. In essence, aside from economic reward, is this the right organization in which to invest?

Economics may catch your attention, but it is not the feature that will keep you in the relationship. A hefty purchase price does little to compensate for a dissatisfying professional environment. Do not over-focus on the financial size of the offer. You can assume that in most markets, the offering price will be competitive within a range. Far more important are the answers to basic questions about the “family” into which you are marrying. Here is a checklist of questions you should ask about the acquiring organization:

1. Does the organization have a long-term market strategy to support its acquisition of medical practices? Why is the system buying practices? Are the reasons visionary or defensive?

continued

2. Is the organization well-funded and positioned to grow?

3. Does it have a wide base of specialty services and a combination of net income and cash reserves to support the system's strategies financially?

4. Is the acquiring organization preferentially seeking to build a broad primary care network, and has it targeted the right geographic and strategic locations for building that network?

5. Is there effective physician leadership within the organization, and is its influence significant?

6. Are physicians involved in recruitment, and is the organization selective about who it hires? Are there quality and performance standards against which physicians are held accountable, or is the organization just in a frenzy to collect doctors?

7. Does the system have a well-articulated managed care strategy that defines how it will go to market (e.g., specific products and partners), or is it merely trying to stave off managed care and ensure inpatient volume?

8. How does the system compare with equally sized competitors in terms of market share and managed care contracts?

9. Does the organization have a reputation for being physician-friendly? Specifically, how do physicians participate in the system, and how much professional and clinical control do physicians have in defining their own destinies?

10. Does the organization have the technical experience and the expertise to manage a physician practice? Does it have dedicated systems and people, apart from its hospital(s), to manage practices?

11. Does it have a compensation plan that rewards physicians based on production, and are features in place to ensure that it does not penalize for adverse payer mix?

12. Do physicians enjoy some form of self-governance in the system?

13. Is there a distinct physician group culture and organization within the ranks of the employed physicians, and is it encouraged by the provider system?

14. Are the professional relationships between the system's physi-

gy that will be used and the valuation specialist who will perform the valuation.

3. Conduct a thorough review of the employment agreement that you will be asked to sign, including payment schedule, tax consequences, vesting requirements, compensation and benefits, noncompete clauses, and other conditions of employment. (See the related article, "Buying Back Your Practice," page 27.)

WHY DO DEALS SOUR?

Many hospital and health care systems with employed physicians manage their networks extremely well. Across the board, their successes relate to their experience and expertise, the presence of long-range market strategies, strong capital bases, preparation for managed care reimbursement systems, and the successful professional and cultural integration of physicians

into the fabric of their organizations.

However, not all health care systems are adequately prepared to welcome physicians into their midst, nor are all physicians ready for the corporate culture of a health care system. There are many reasons why physicians and systems become dissatisfied following the sale of practices and why one or both parties might look for a way to reverse the sale. Typically, the problem stems from seller's remorse, system incompatibility, professional incompatibility, economic issues, or a combination of these factors.

SELLER'S REMORSE

In hindsight, physicians sometimes find that selling their practice was not a wise decision. After years of independence and autonomous decision-making, physicians may find it impossible to make the transition from private practice to employment. The physicians simply are not ready



cians harmonious?

15. Regardless of the idiosyncrasies of the system itself, are these the types of physicians with whom you would like to practice? Would you agree to share call and let potential partners see your patients?

MAKING THE DEAL

Remember, selling your practice will likely be the most important professional transaction you make; have competent business and legal advisers carefully review the terms of employment agreements and other documents with you. And take the following steps to assure a collegial transaction:

1. Agree on what will be purchased (i.e., tangible or intangible assets or both). This should be spelled out in a letter of intent between the physicians and the system before actual negotiations begin.

2. Agree on how the practice will be valued, including the methodolo-

to become employees. The sellers should have known better but may have been seduced by an attractive purchase price and the unrealistic notion that they could continue to participate in decision-making.

SYSTEM INCOMPATIBILITY

Deals can sour because of the acquiring system. The environment that was promised to the physicians and the one that was delivered may not match up. As a professional group, physicians do not usually do well in bureaucratic organizations with complex political relationships—either in hospital- or physician-owned systems. Physicians accustomed to rapid decision-making (not unlike in medical practice itself) are sometimes frustrated by the hurdles that large health care systems may impose. In addition, the system may not have been technically prepared to manage physician practices.

PROFESSIONAL INCOMPATIBILITY

Professional incompatibility among physician peers is a frequent reason why practice acquisitions go bad. Recently employed physicians may feel dissatisfied with partners who were not of their own choosing. Professional incompatibility often arises when a system's recruiting lacks physician involvement (e.g., administrators and recruiters alone hire new physicians) and lacks strategic direction for the employed physicians. Systems that employ physicians without a clear plan for selecting them often find that instead of a cohesive group, they have little more than a collection of employment contracts awkwardly strung together. As a result, group culture is missing.

ECONOMIC ISSUES

Deals also founder because the physician compensation plan does not work or does not exist. Maybe the practice purchase price and the starting salary were carefully considered, but no one thought much about how physicians would be compensated once in the system. As a result, anticipated annual compensation targets and bonus opportunities are either unrealistic or unattainable. Today, successfully integrated health care

systems involve physicians in compensation plan design and implementation, and they use compensation systems² that factor in:

- overhead management and expense control;
- committee work and related

system activities; and

- overall system performance.

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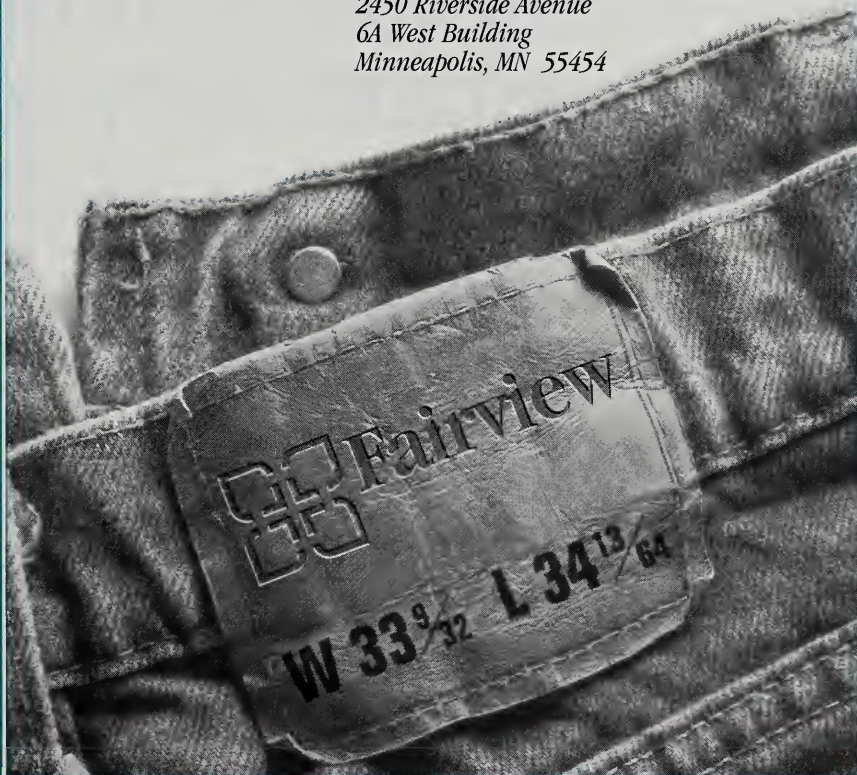
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perceived as well-integrated does not mean that it is. Physicians contemplating the sale of their practices should look for certain characteristics in their new professional homes. The critical characteristics to look for in a well-positioned physician-

friendly system include:

- a commitment to move beyond inpatient-only thinking and involve physicians in doing business differently;
- leadership that has a clear business vision and knows where the

organization is going;

- alignment with other providers to deliver a complete spectrum of care (i.e., services beyond the capability of the system itself);
- access to information systems and technology;
- evidence of, or a willingness to move toward, significant physician leadership within the executive ranks of the organization; and
- nonphysician executive leadership that is sensitive to physician professional needs and that is capable of cooperating with physicians.

CONCLUSION

As managed care pressures accelerate, health care systems will likely continue to purchase physician clinics. And while the economics of selling a practice will remain important, issues of subsequent employment, professional compatibility, and the overall business wisdom associated with becoming part of an integrated system will take on greater significance for physicians. Practice sale is akin to a business marriage and implies a long-term commitment from both parties. As you assess your opportunities, methodically look at all aspects of the transaction to help ensure that you make the right professional, as well as the right financial, choice. MM

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REFERENCES

1. Jaklevic MC. Buying doc practices often leads to red ink. *Mod Healthc* 1996;26(23):39-44.
2. Zisner DK, Collins JJ. Physician compensation for system-based primary care networks. *Partners' Integration Advisor* 1994;2(2):1-2.

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Buying Back Your Practice

Negotiate before selling your practice if you want to leave the door open for buying it back.

Thomas J. Doyle, J.D.

Hospitals and health care systems are eagerly acquiring physician practices, and it's no secret that some physicians who sell their practices subsequently wish they could turn back the clock. Unfortunately for those with regrets, none of these deals comes with ruby slippers; you cannot just click your heels and be back where you started.

Planning ahead when you sell your practice may provide the only possibility of buying it back later. Consider this analogy: A man and woman contemplating marriage enter into a premarital agreement that settles their property rights should the marriage fail. Through a premarital agreement, they can specify a different outcome than what the law otherwise would impose. Physicians may be able to do the same when negotiating the sale of their practice in case the new employment arrangement sours.

But given human nature, discussing a premarital agreement during the courtship can be difficult. Just mentioning the topic may raise doubts about commitment. Certainly, a decision to sell your practice by no means brings into play the same considerations or emotions as a marital engagement; nevertheless, it can be hard to broach the possibility of a future falling out when both sides are striving to build a strong business and professional relationship. Still, it is important to assess frankly where you might stand if the relationship does not work.

WHAT WOULD BE BOUGHT BACK?

When a physician sells a practice, the sale may include stock or assets (see "The Physician-Hospital Integration Sensation" by Forrest Burke, *Minnesota Medicine*, April 1994). In either case, the physician generally loses his or her ownership interest in all of the practice's assets—the tangible assets, such as medical equipment and supplies, office furniture and equipment, and computers, as well as the intangible assets, such as goodwill, the practice name, patient lists, and the value of the assembled clinical work force. Accounts receivable may or may not be transferred with the practice.

When you think of buying back the practice, it's unlikely you would really contemplate buying back all of the assets. The key element of a buy-back is probably your ability to end the employment or contract relationship with the purchaser and to reestablish your independent practice. You may think of a buy-back as recovering the goodwill and ongoing patient relationships that were a part of your former practice, and perhaps the ability to use the old practice's name. Probably of less importance is the right to buy back particular tangible assets. Medical and office equipment can be bought anywhere. So let's turn first to reestablishing an independent practice.

NONCOMPETE COVENANTS

When a physician sells his or her practice, the purchaser (or some affiliate) may well employ the physician. As part and parcel of the employment agreement, the purchaser likely will require a covenant not to compete, or a "noncompete" (see "Physician Employment Agreements—What to Look For" by James B. Platt, *Minnesota Medicine*, July 1995). Your first tack may be to avoid a noncompete or negotiate broad exceptions. But that may cause the purchaser to lower its offer* or to become nervous about your commitment. Possibly, all you need—or can afford—is the right to buy out of the restrictions imposed by the noncompete, and perhaps a right to buy back your practice's old name.

As a practical matter, it may be easier to fix in advance the price for buying out of a noncompete and buying back the right to use a name than to fix a price for buying back *all* of the assets. (This assumes the buy-back does not include a requirement that the selling hospital or system not compete with *you* after the transaction.) Even if you can end the noncompete, bear in mind that you will need to purchase, lease, or otherwise

*Practice valuations are generally on a discounted, projected cash flow. Cash flow depends on revenue producers being present. In most purchasers' minds, that means you.

obtain the other items necessary to reestablish a practice, such as space and medical and office equipment. In addition, the right simply to buy out of your noncompetitor may not enable you to use the name under which you previously practiced.

An employer's rights under a noncompetitor are valuable. A tax-exempt hospital or system cannot give away assets, lest it risk its tax-exempt status. In addition, releasing a physician from a noncompetitor without compensation conceivably could constitute "remuneration" under the anti-kickback law. For these reasons, the purchaser may require reasonable payment to end a noncompetitor.

TANGIBLE ASSETS

The legal questions related to buying back tangible assets are nettlesome. First, if you reserve the right to buy back certain assets, especially at a fixed price, this could be construed as an "ownership interest" in the purchaser, which could cause legal concerns under Stark II (under Stark II, an ownership or investment interest may be through equity, debt, or "other means"). If so, and if you will refer patients to the purchaser for any services covered by Stark II, you must be sure that your ongoing relationship with the purchaser meets one of the Stark II exceptions to its ownership or investment prohibition. (For a review of the Stark laws, see "Laws Prohibiting Physician Self-Referrals" by Margo Struthers and Patricia Smith, *Minnesota Medicine*, January 1996.)

If you want to negotiate a broad buy-back right that encompasses the entire practice with all its assets, comparable to what you are selling, do not expect to fix the purchase price in advance. The purchase price for a medical practice is typically the single biggest issue in a practice sale. It raises tax-exemption concerns (if the purchaser is exempt) and potential Medicare/Medicaid anti-kickback concerns (see "The Physician-Hospital Integration Sensation," Part 2, by Forrest Burke, *Minnesota Medicine*, May 1994). These same concerns exist whether you are the seller or buyer. Moreover, just reserving the right to buy back significant assets

may depress the value of the practice you are selling, and it may reduce what the purchaser can justify as fair market value.

PRICE AND PAYMENT TERMS

Whatever right you reserve, whether it is a right to buy out your noncompetitor or the right to buy back assets, legal considerations may preclude the purchaser from discounting the amount you must pay. You will likely have to pay fair market value, although this may be difficult to determine in advance, and the purchaser may well have qualms about fixing a price for a possible future buy-back.

You will also want to negotiate whether the buy-back can be paid over time and, if so, the terms. Again, a purchaser may have tax-exemption and anti-kickback concerns about any terms or conditions that are more generous than would be available from a bank or other commercial financing source. If you were to get financing from a commercial source, a personal guaranty and/or other security may be required. Legal concerns may compel a purchaser to require the same.

OTHER BARRIERS

Buying back any aspect of your practice involves a number of challenges. Some of these can be addressed in negotiations between you and the purchaser, but many are beyond your control. Here is a brief description of some barriers you may encounter when buying back your practice:

1) Presumably, the entity that bought your practice will remain in place and operating. The allegiances of some patients and referral sources may have shifted. Essentially, through your good efforts as an employee or contractor of the purchaser, you will have helped create a new competitor.

2) You will need to reassemble your staff. Some or all staff members may have become employees of the purchaser; some may have gone elsewhere. One or more of them may have signed a noncompetitor. You likely will need to recruit and train a new staff and establish new work patterns and practices.

3) You will need to line up financing, including funds to buy out

your own noncompetitor and the noncompetitor of any essential staff member or to purchase medical office equipment (although it may be possible to finance that via leases). In any event, you will need cash to meet operating costs (payroll, rent, utilities, supplies, and the like) until you have sufficient revenue.

4) You will also have to reestablish your practice with patients, referral sources, and others. If you want to mail an announcement, you will need access to the practice's records, at least to get patient names and addresses. A right to such access should be negotiated before the sale. If you wish to use your practice's old name, you will need to buy it back. Access to patient records and use of a name are key elements of goodwill. If you wish to have these back, undoubtedly you will need to pay fair value.

CONCLUSION

If you think you might want to reestablish your own practice in the same area, at a minimum consider negotiating appropriate exceptions to any noncompetitor. If exceptions are not possible, you may want to negotiate a right to buy your way out of the noncompetitor. If the purchaser plans to use your practice's name, and if you would need this and perhaps other practice assets, you may wish to raise the possibility of a more comprehensive buy-back right. But do not expect to do any of this without cost. Legal considerations, the purchaser's obligation to protect and preserve its assets, and common-sense business practices all compel arm's-length dealing. That, in turn, means the purchaser will expect fair compensation for these valuable rights and assets you want to buy back. **MM**

The preceding general discussion is designed to alert physicians to issues they may wish to consider in the sale of a medical practice. It is not legal advice and should not be relied upon as such.

Tom Doyle is a shareholder of Felhaber, Larson, Fenlon & Vogt, P.A. Part of his practice is in the health law area, including transactions between hospitals and health care systems and physicians.

Minnesota Rickets

Need for a Policy Change to Support Vitamin D Supplementation

Erica A. Eugster, M.D., Kumud S. Sane, M.D., and David M. Brown, M.D.

ABSTRACT

Vitamin D deficiency rickets, once considered the most common disease of early childhood, was reported to have disappeared by the 1960s. However, during a recent 18-month period, seven cases of nutritional rickets were diagnosed in the Twin Cities metropolitan area. All of the patients were born at term and were breastfed without supplemental vitamins. Three of the patients were Caucasian, three were African American, and one was biracial. This case series demonstrates the risk of nutritional rickets in breastfed infants in our northern climate, regardless of race. In hopes of eradicating this completely preventable disease, we advocate a uniform policy of vitamin D supplementation to breastfed infants.

Rickets secondary to vitamin D deficiency was once considered the most common disease of early childhood. The advent of vitamin D-fortified milk in the 1920s, together with the recognition of the role sunlight plays in the endogenous production of vitamin D, dramatically decreased the incidence of nutritional rickets. By the mid-1960s, rickets was reported to have essentially disappeared from the United States.¹ Despite this apparent success, nutritional rickets is far from eradicated. In a recent 18-month period, seven cases of vitamin D deficiency rickets were diagnosed in the Twin Cities metropolitan area. In all cases, the patients were born at term and were breastfed without receiving supplemental vitamins.

CASE SUMMARIES

The patients were between 6 and 20 months of age at diagnosis and presented between February and May. Two patients presented with symptoms of hypocalcemia, two with failure to thrive, and two with neurologic symptoms. One patient was diagnosed during a well-child exam. Physical findings varied among the patients and included frontal bossing, large anterior fontanel, craniotabes, enlarged wrists, and rachitic rosary. Height and weight were below the fifth percentile in four patients and greater than the fifth percentile in three. Serum calcium was low in five patients, and serum phosphorus was low in six. All patients had elevated levels of parathyroid hormone (PTH) and alkaline phosphatase. Five patients had low levels of 25-hydroxyvitamin D. Two patients had low-normal levels of 25-hydroxyvitamin D, although classic findings of rickets were present on physical exam and x-rays. When

measured, levels of 1,25-dihydroxyvitamin D were normal (two patients) or elevated (two patients). Radiographic findings included metaphyseal flaring, cupping, and fraying, as well as diffuse osteopenia. Clinical, radiographic, and laboratory abnormalities resolved in every instance with vitamin D supplementation. Three cases are described in greater detail below.

CASE DESCRIPTIONS

PATIENT 1

A 20-month-old white boy with a history of regressing gross motor skills presented to a neurologist. The child was able to pull to a stand at 12 months and began cruising shortly after. However, for the several months before he was examined, the child had become increasingly reluctant to stand and seemed to be weak, especially in the legs. He would not push himself up when prone and had trouble getting to a sitting position. Physical exam revealed that his height and weight, which had been at the 50th percentile at 9 months, were now below the fifth percentile. The patient had diffuse hypotonia, muscle weakness, and muscle atrophy.

Neurologic work-up consisted of MRI scans of the brain and spine, metabolic screening, and multiple routine laboratory tests; the results were normal with the exception of hypocalcemia. The patient was then referred to an endocrinologist. Dietary history revealed that this patient had been exclusively breastfed for the first several months of life and then switched to unfortified goat's milk because of "intolerance" to standard formula. Solid food intake consisted primarily of carbohydrates, vegetables, and fruit. Additional physical findings included an open an-

Table

*Characteristics of seven patients diagnosed with rickets (dates)**

Case	1	2	3	4	5	6	7
Age (mos)/Race	20/white	6/black	18/white	8/black	8/Iranian	6/black	6/mixed
Month of diagnosis	April	February	April	February	May	April	February
Presentation	Gross motor regression	Tetany	Developmental delay	Seizure	Failure to thrive	Well-child visit	Failure to thrive
Physical exam	Open fontanel Enlarged wrists Rachitic rosary Ht/wt<5th%	Enlarged wrists	Enlarged wrists Ht/wt<5th%	Frontal bossing Enlarged wrists	Ht/wt<5th%	Craniotabes Rachitic rosary	Enlarged wrists Rachitic rosary Ht/wt<5th%
Calcium (mg/dl)	6.2	6.2	9.4	5.8	7.6	8.5	5.6
Phosphorus (mg/dl)	3.2	2.1	2.4	3.3	4.1	3.1	3.6
PTH (pg/ml)	75	237	405	110	79	386	766
Alkaline phosphatase U/l	3,426	737	2,628	1,250	470	747	2,028
25-Vit D (ng/ml)	<5	5	<10	12	4	18	10
1,25-Vit D (pg/ml)	42	ND	ND	ND	110	200	17
X-ray findings	rickets	rickets	rickets	rickets	normal	rickets	rickets
Treatment	Calcium Vitamin D ₃ 0.5mcg/d	Calcium Vitamin D ₂ 5,000 U/d	Vitamin D ₂ 40,000 U/d	Calcium Vitamin D ₂ 5,000 U/d	Calcium Vitamin D ₂ 5,000 U/d	Vitamin D ₂ 400 U/d	Vitamin D ₂ 5,000 U/d

*All laboratory results are measured in serum. Normal values: calcium 8.5-10.6 mg/dl; phosphorus 3.8-6.5 mg/dl; PTH <10-65 pg/ml; alkaline phosphatase 140-420 U/L; 25-hydroxyvitamin D 10-55 ng/ml; 1,25-dihydroxyvitamin D 15-90 pg/ml.

terior fontanel, swollen wrists, and rachitic rosary. Laboratory and x-ray findings are presented in the table.

PATIENT 2

A 6-month-old black male infant presented to the emergency room with a history of vomiting and diarrhea. The patient was admitted because of significant dehydration and was diagnosed with Rotavirus gastroenteritis. On the fourth day of hospitalization, the baby was found to be in tetany with rigidly extended extremities. Calcium was 6.2 mg/dl, and the patient was treated with intravenous calcium. This baby had been exclusively breastfed since birth. Additional laboratory studies and x-rays are presented in the table.

PATIENT 3

An 18-month-old white girl presented with a history of developmental delay. She was neither crawling nor walking, although she had been able to sit at 9 months and cruise at 15 months. Development in personal, social, language, and fine motor areas were age appropriate. Physical exam revealed height and weight below the fifth percentile, swollen wrists, and truncal hypotonia with muscle atrophy in the trunk and shoulder regions. The child had been breastfed since birth and was started on solids at 4 to 6 months. Laboratory and x-ray studies are presented in the table.

DISCUSSION

The association between breastfeeding and nutritional rickets has been acknowledged for many years.^{2,3} Breast milk has been shown to contain only small amounts of vitamin D₂ (ergocalciferol) and D₃ (cholecalciferol), with negligible levels of the more active metabolites, 25-hydroxyvitamin D and 1,25-dihydroxyvitamin D.^{4,5} Vitamin D levels in human milk are affected by race, diet, and ultraviolet light exposure, but they average 35 IU/L in black women and 68 IU/L in white women.⁶ It has been estimated that a maternal vitamin D intake of at least 3,000 IU or repeated ultraviolet exposure is required to raise breast milk vitamin D levels to at least 100 IU/L.⁷ Even this level would provide far less than the daily

intake of 400 IU recommended by the Food and Nutrition Board of the National Academy of Sciences. Thus, although maternal vitamin D status influences the vitamin D concentration in breast milk, it appears that additional sources of vitamin D are necessary for exclusively breastfed infants, either through supplementation, adequate sunlight exposure, or a combination of both.

Dark skin pigmentation has long been recognized as a risk factor for developing nutritional rickets. Studies show that a sixfold increase in ultraviolet light exposure is required to raise serum vitamin D levels in deeply pigmented people to the same degree as that seen in Caucasians.⁸ Even in a southern climate, where sunlight exposure is plentiful, nutritional rickets in breastfed black infants has been recently reported.⁹ Other identified risk factors in the development of vitamin D-deficiency rickets include poor intake of solid foods, prematurity, strict vegetarianism, inner-city dwelling, and restricted sunlight exposure because of northern climates or traditional beliefs dictating that the body be kept covered when outside the home.¹⁰

The clinical presentation of nutritional rickets can take several forms, including hypocalcemic seizures and developmental delay. Vitamin D deficiency shows a striking propensity to masquerade as a serious neurological disorder, as seen in patients 1 and 3. The spectrum of biochemical abnormalities found in our patients reflects the different stages of the disease (see the table). The first stage, caused by decreased intestinal absorption of calcium, is characterized by hypocalcemia and secondary hyperparathyroidism with a subsequent increase in alkaline phosphatase. The serum phosphorus is normal. Parathyroid hormone-induced bone resorption leads to a normalization of serum calcium in stage two, along with the development of hypophosphatemia and hyperaminoaciduria. Levels of 1,25-dihydroxyvitamin D can be extremely elevated in this stage of rickets, as seen in patient 6, because of maximally stimulated renal hydroxylation of 25-hydroxyvitamin D. In the third and most

severe stage of rickets, hypocalcemia returns caused by extreme depletion of vitamin D stores, despite continued secondary hyperparathyroidism.^{11,12} Advanced stages of the disease are accompanied by progressive growth failure as well as deformities of the legs, thorax, and spine, which, if untreated, become permanent.

The American Academy of Pediatrics does not recommend vitamin D supplementation for all breastfed babies, but only for those who are deeply pigmented or who do not have adequate sunlight exposure,¹³ estimated to be 30 minutes per week clothed in only a diaper or two hours a week fully clothed with no hat.¹⁴ In accordance with this recommendation, it has become common practice among pediatricians not to prescribe supplemental vitamin D for the breastfed babies in their practices. An informal survey among the third-year residents in our large training program revealed that 48% do not routinely prescribe vitamin supplementation to the exclusively breastfed babies they care for in their clinics. Resident continuity clinics are conducted under the supervision of community pediatricians who are based in a variety of outpatient settings.

Our study is only one of several recent case series documenting nutritional rickets in North America.^{9,15-17} Although the exact incidence of vitamin D deficiency in Minnesota and other areas is unknown, the number of published reports of rickets during recent years appears to have increased. This could be because of a decrease in the rates of vitamin D supplementation by primary care providers, an increase in the number of mothers choosing to breastfeed, or both. Four of our patients are deeply pigmented and, thus, fall into a well-defined risk group. The remaining three are Caucasian babies who undoubtedly developed rickets because of a lack of dietary vitamin D related to prolonged breastfeeding or unfortified milk combined with inadequate ultraviolet light exposure. For at least five months of the year in our northern climate, the amount of direct sunshine available to the average infant is far less than that estimated to be required for vitamin D sufficiency.

cy. Particularly vulnerable are babies born in the late summer or early fall, as demonstrated by the clinical presentation of rickets occurring in late winter and early spring.

Exclusively breastfed Caucasian babies born to mothers who took prenatal vitamins throughout their pregnancies may not require vitamin D supplementation during the first six months of life.^{18,19} However, infants who continue to be exclusively breastfed after six months or who have unusual diets (such as goat's milk) or poor solid food intake are at risk for developing rickets. In the context of the typical busy pediatric or family practice clinic, which serves a diverse patient population, we believe that the simplest and safest approach is to provide supplemental vitamin D to all breastfed babies, regardless of race or maternal vitamin D status, at least in northern latitudes.

The recommended daily intake of 400 IU of vitamin D per day is effective, cheap, and extremely safe.²⁰ In the interests of truly eradicating this completely preventable disease, we strongly advocate a policy change

in primary care practice calling for uniform vitamin D supplementation for breastfed infants.

MM

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REFERENCES

1. Harrison HE. The disappearance of rickets. *Am J Public Health* 1966;56:734-7.
2. O'Connor P. Vitamin D-deficiency rickets in two breast-fed infants who were not receiving vitamin D supplementation. *Clin Pediatr* 1977; 16:361.
3. Edidin DV, Levitsky LL, Schey W, Dumbovic N, Campos A. Resurgence of nutritional rickets associated with breast-feeding and special dietary practices. *Pediatrics* 1980;65:232-5.
4. Hollis BW. Individual quantitation of vitamin D₂, vitamin D₃, 25-hydroxyvitamin D₂, and 25-hydroxyvitamin D₃ in human milk. *Anal Biochem* 1983;131:211-9.
5. Greer FR, Ho M, Dobson D, Tsang RC. Lack of 25-hydroxyvitamin D and 1,25-dihydroxyvitamin D in human milk. *J Pediatr* 1981;99:233-5.
6. Specker BL, Tsang RC, Hollis BW. Effect of race and diet on human-milk vitamin D and 25-hydroxyvitamin D. *Am J Dis Child* 1985;139:1134-7.
7. Hillman LS. Mineral and vitamin D adequacy in infants fed human milk or formula between 6 and 12 months of age. *J Pediatr* 1990; 117 (suppl):134-42.
8. Clemens TL, Henderson SL, Adams JS, Holick MF. Increased skin pigment reduces the capacity of skin to synthesise vitamin D₃. *Lancet* 1982;1:74-6.
9. Bhowmick SK, Johnson KR, Rettig KR. Rickets caused by vitamin D deficiency in breast-fed infants in the southern United States. *Am J Dis Child* 1991;145:127-30.
10. Bachrach S, Fisher J, Parks JS. An outbreak of vitamin D deficiency rickets in a susceptible population. *Pediatrics* 1977;64:871-7.
11. Fraser D, Koogh SW, Scriver CR. Hyperparathyroidism as the cause of hyperaminoaciduria and phosphaturia in human vitamin D deficiency. *Pediatr Res* 1967;1:425-35.
12. Kruse K. Pathophysiology of calcium metabolism in children with vitamin D-deficiency rickets. *J Pediatr* 1995;126:736-41.
13. American Academy of Pediatrics, Committee on Nutrition. Vitamin and mineral supplement needs. In: *Pediatric nutrition handbook*. Elk Grove Village, Illinois: American Academy of Pediatrics, 1993:36-41.
14. Specker BL, Valanis B, Hertzberg V, Edwards N, Tsang RC. Sunshine exposure and serum 25-hydroxyvitamin D concentrations in exclusively breast-fed infants. *J Pediatr* 1985;107:372-6.
15. Lebrun JB, Moffatt MEK, Mundy RJT, et al. Vitamin D deficiency in a Manitoba community. *Can J Public Health* 1993;84:394-6.
16. Sills IN, Skuza KA, Horlick MNB, Schwartz MS, Rapaport R. Vitamin D deficiency rickets: reports of its demise are exaggerated. *Clin Pediatr* 1994;33:491-3.
17. Shah BR, Finberg L. Single-day therapy for nutritional vitamin D-deficiency rickets: a preferred method. *J Pediatr* 1994;125:487-90.
18. Birkbeck JA, Scott HF. 25-hydroxycholecalciferol serum levels in breast-fed infants. *Arch Dis Child* 1980;55:691-5.
19. Greer FR, Marshall S. Bone mineral content, serum vitamin D metabolite concentrations, and ultraviolet B light exposure in infants fed human milk with and without vitamin D₂ supplements. *J Pediatr* 1989;114: 204-12.
20. Chesney RW. Requirements and upper limits of vitamin D intake in the term neonate, infant, and older child. *J Pediatr* 1990;116: 159-66.

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ANNOUNCEMENTS

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COME TO THE MMA ANNUAL MEETING

All Minnesota Medical Association members are invited to attend the 143rd MMA Annual Meeting to be held at the Northland Inn in Brooklyn Park September 18 to 20, 1996. The MMA House of Delegates will be in session on Thursday, September 19, and Friday, September 20.

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MMA E-MAIL

You can now send E-mail directly to MMA staff. The E-mail address is: the initial of the first name, the last name, followed by @mnmed.org.

For example, the E-mail address of *The Monitor In Brief* editor is: lholmrgren@mnmed.org

The E-mail address of the MMA is: mma@mnmed.org

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MMA/MSBA Will Hold JOINT MEETING

The Minnesota Medical Association and the Minnesota State Bar Association invite you to attend a breakfast meeting September 10 from 7 a.m. to 9 a.m. at the Sheraton Inn Midway in St. Paul. For more information, call Vicki Westling at the MMA, 612/378-1875 or 800/999-1875.

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Correction

Andrew J. K. Smith, M.D., was elected chair of the Midwest Medical Insurance Company Board of Directors. David Bounk is president and CEO of MMIC. Smith's title at MMIC was incorrectly reported in the July *Monitor*.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

AMA Adopts Minnesota Resolutions

AMA Reaffirms Immunization Resolution

At the 1996 American Medical Association Annual Meeting in Chicago in June, the AMA House of Delegates reaffirmed a Minnesota resolution asking the AMA to seek federal legislation requiring self-insured companies to cover immunizations as recommended by the National Advisory Vaccine Committee. Since states have no authority to require self-insured companies to cover immunizations, federal legislation is necessary.

AMA Responds to MMA's Interpreter Resolution

In response to a 1995 Minnesota resolution, the AMA resolved to seek immediate clarification from the U.S. Department of Health and Human Services on how Medicaid requirements regarding the use of bilingual services apply to physicians' offices and, if appropriate, to seek reimbursement for such services. In addition, the AMA will explore the feasibility of assuring payment for qualified interpreter services that are required by the Americans With Disabilities Act (ADA) if the cost of such services exceeds the available tax credits and the amount of reimbursement. Under the ADA, all physician offices are required to provide auxiliary aids and services for patients with hearing loss without charge to the patient. The AMA will also continue to monitor the enforcement of the federal Civil Rights Act and of the ADA requirement that the recipients of federal funding and "public

accommodations," such as physician offices, provide qualified interpreters and translators.

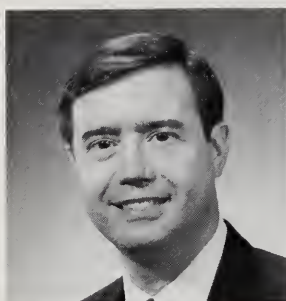
Under the Civil Rights Act, HHS has enforced a requirement to establish effective communication procedures for persons with limited English proficiency against hospitals, other health care institutions, and agencies certified to participate in the Medicare and Medicaid programs, state agencies administering the Medicaid program, and physician offices with 15 or more employees.

The Minnesota delegation was very pleased with the AMA action, according to C. Randall Nelms, M.D., a St. Paul otolaryngologist and past president of the MMA. "The AMA gave us everything we asked for," said Nelms. The 1995 Minnesota resolution originally asked the AMA to 1) study the legal requirements to provide qualified medical interpreters, 2) work with government agencies to develop a definition for "qualified medical interpreter," 3) if appropriate, develop model legislation to clarify the responsibilities of physicians to make available interpreter services, and 4) provide a report to the AMA House of Delegates.

At the 1995 Interim Meeting, the AMA Board of Trustees report on interpreters was referred back to the board for further clarification of existing law.

The 1996 AMA reference committee, which considered the AMA Board of Trustees report, noted that

Resolutions continued on page 35



Viewpoint

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Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

What Will Medical Education Be Like in the 21st Century?

Dramatic changes are in store for medical education in Minnesota. The competitive, managed care market requires a new approach to the traditional ways of educating physicians. In the past, the University of Minnesota Academic Health Center (AHC) excelled in educating specialists in tertiary care hospitals. Now the marketplace is demanding primary care physicians who can supervise health care teams that include allied providers. Health plans are increasingly unwilling to cover the research and education costs that are built into higher prices at teaching hospitals. Tuition covers only a fraction of the cost of educating a physician. The estimated cost of medical student education is approximately \$45,645 per student per year, but tuition at the U of M Medical School is \$14,616 per year for the first three years and \$3,654 for the fourth year.

Radical solutions are required. The university has embarked on an ambitious plan for transforming itself to survive in the new health care environment and to educate the physicians of the 21st century. Former Provost William Brody, M.D., Ph.D., announced a restructuring of the AHC before he left to become president of Johns Hopkins. Now the former medical school dean, Frank Cerra, M.D., has replaced Brody, and a nationwide search is under-

way to find a new dean to help guide the university through its reengineering process. As a member of the search committee, I am keenly aware of the importance of finding a visionary leader who will be able to find creative solutions and build on the university's tradition of excellence.

Among the university's successes is the Rural Physician Associate Program (RPAP). In RPAP, third-year medical students spend nine to 12 months working with a rural family physician. This gives medical students an opportunity to provide direct patient care and to form mentor relationships with physicians. This innovative program, which the university initiated in 1970 to increase the number of physicians going into rural practice, is a model of collaboration between the public and private sector. In the future, RPAP might serve as a model for medical education in urban or suburban areas and might be expanded to include specialties other than primary care.

Building on successes such as RPAP, the AHC of the future will continue to be a top-notch educational institution that graduates competent, compassionate physicians. To prepare the physicians of the future for a managed care market that stresses cost-effective care provided by interdisciplinary teams, the medical school will not only provide students with clinical skills and an introduction to research for those who may

wish to pursue a Ph.D., but it will also stress public health, case management, and patient relations. Physicians will have to be on top of the latest clinical information, skilled in collaborating with community leaders, knowledgeable about public health issues, and firmly grounded in moral and ethical values. It's a tall order.

Faced with these challenges, the AHC will need to explore new, creative ways to teach medical students. It is essential for the new dean to have enthusiasm for new teaching methods along with a determination to study the effectiveness of any new methods.

The success of the university's revitalization depends not only on its leaders, however, but also on the ability to find funding for medical education. Some of the money for restructuring the AHC will come from the merger between the University of Minnesota Hospital and Clinic and Fairview Health System. Some of the money will come from the state, and some must come from the health plans. Last session, the MMA helped push through legislation that provided funds for the AHC.

Additional impetus for state funding of medical education came from the Medical Education and Research Cost (MERC) Task Force's 1996 report to the Legislature, which calls on the state to establish a Medical Education and Research Trust Fund to provide stable funding for medical education, rather than relying on patient care revenues.

One of the task force's guiding principles was that all health care purchasers, including public, private, and individual purchasers, should help finance medical education and research. The task force stressed that self-insured companies should contribute their fair share. Funding for medical education should come from the health plans that benefit from having well-trained physicians.

The MMA will continue to support the university in its reengineering of medical education to assure the excellence of physicians in the future.

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Resolutions continued from page 33

once the AMA has exhausted negotiations with the U.S. Department of Health and Human Services, re-evaluation of the need for legislation would be appropriate. The committee recommended that the AMA not limit itself to a legislative approach to assuring payment for interpreter services. In addition to developing model legislation, the AMA should investigate complementary or alternative routes such as cooperative ventures with organizations representing the hearing impaired.

Minnesota Physicians Prominent at AMA Meeting

The Minnesota delegation, chaired by Richard B. Tompkins, M.D., includes delegates Robert D. Christensen, M.D.; E. Duane Engstrom, M.D.; A. Stuart Hanson, M.D.;

Andrew J. K. Smith, M.D.; Audrey M. Nelson, M.D.; Ben P. Owens, M.D.; and alternate delegates, Frank J. Indihar, M.D.; Theodore L. Fritsche, M.D.; Thomas L. Peyla, M.D.; John Van Etta, M.D.; Carolyn J. McKay, M.D.; Bruce A. Norback, M.D.; and Lyle Munneke, M.D.

This was Tompkins' last meeting as member and chair of the Minnesota delegation. He is leaving the Minnesota delegation to represent the American Medical Group Association in the AMA House of Delegates. Hanson was elected to replace him as chair of the Minnesota delegation, and Nelson was elected vice-chair, replacing Hanson in that position.

MMA past president C. Randall Nelms, M.D., represented the American Academy of Otolaryngology-Head and Neck Surgery on the reference committee dealing with science

and technology, and Minnesota delegate E. Duane Engstrom, M.D., served on the reference committee dealing with medical practice and facilities.

In a regional note, Cyril (Kim) Hetsko, M.D., of Wisconsin, who is president of the North Central Medical Conference, was elected to the AMA Council on Medical Service.

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Van Etta Comments on AMA Opposition to Assisted Suicide

During the AMA Annual Meeting in Chicago, Minnesota alternate delegate John Van Etta, M.D., gave a telephone interview on physician-assisted suicide that aired on WCCO radio in the Twin Cities. In the wake of two court decisions overturning state bans on assisted suicide, the media focused on this issue even though there was almost no disagreement in the AMA House of Delegates. With only one dissenting vote, the AMA reaffirmed its opposition to physician-assisted suicide and issued a report recommending the use of palliative measures.

In the radio interview Van Etta said, "We need to do a better job as a profession and as a society in educating people and eliminating the need for assisted suicide. Our patients are not a can of corn with an expiration date on the label. They mean more to us than that. The physician is there to see the patient and family through a stage of life we're all going to go through."

When asked if it wouldn't be more merciful to end a life when the quality is minimal, Van Etta answered, "My professional obligation is to make sure my patients have no pain. In my 15 years of practice as a primary care physician, I have never seen a patient die in agony or pain. Our job is to manage pain and depression so that the patient and family are comfortable during the death process."

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MMA Sponsors "Stop the Violence Day at the Dome"

• • • • • SEE THE MINNESOTA TWINS take on the Chicago White Sox on "Stop the Violence Day at the Dome" Sunday, September 29. The Minnesota Medical Association is one of the main sponsors of this event, which will focus attention on the problem of violence. A pre-game rally beginning at noon on the Plaza will feature music, food vendors, and entertainment as well as displays by violence prevention organizations. The game begins with a Major Scoreboard Welcome at 1:05 p.m. Special half-price lower level seating is available for only \$6.

"Stop the Violence Day at the Dome" is also sponsored by the Minnesota Attorney General Hubert H. Humphrey III, Ramsey/Hennepin Initiatives for Violence

Free Families & Communities, University of Minnesota's Children, Youth and Family Consortium, and WomanKind/Fairview Health System. It is co-hosted by a growing list of organizations including Minnesota Cable Communications Association, Minnesota Hospital and Healthcare Partnership, Minnesota Nurses Association, Minnesota Council of HMOs, Center for Reducing Rural Violence/Citizens Council, Allina, Blue Cross and Blue Shield of Minnesota, HealthPartners, Citizens for a Safer Minnesota, Ramsey Medical Society, and Hennepin Medical Society.

For more information, call Mark Vukelich at the MMA, 612/378-1875 or 800/999-1875.

AMA Reaches Compromises on Medicare Issues

Delay Resource-Based Practice Expenses

At the AMA Annual Meeting, AMA delegates debated whether to press for speedy development and implementation of new resource-based practice expense relative values or to seek a delay so that results of a national survey of physicians' practice expenses can be used in their development. Medicare fee-for-service reimbursement for physician services is based on the relative costs of three components: 1) work, 2) malpractice, and 3) practice. The current practice relative values are based on historical Medicare charges and thus lock Minnesota physicians into comparatively low Medicare rates. The Health Care Financing Administration is developing new practice relative values that are intended to reflect actual practice costs, but in order to comply with federal law requiring implementation of the new RVUs in 1998, HCFA cannot wait until its national study of physician practice expenses is completed.

Physicians, especially those in primary care, are becoming impatient. Implementation of the practice relative values has already been delayed since 1992. Lyle Munneke, M.D., a family practice physician from Willmar and an AMA alternate delegate, told *The Monitor* that this issue divided AMA delegates along specialty lines with surgeons urging delay while family practice and internal medicine physicians wanted new, more equitable Medicare rates implemented as quickly as possible.

"HCFA made it very clear that they will have to use inadequate data in order to keep to the schedule set by Congress," said Minneapolis surgeon Robert D. Christensen, M.D., an AMA delegate. "We argued for the AMA to lobby Congress to delay the start-up date for one year to give HCFA plenty of time to use accurate, good data."

"I can live with a one-year delay in order to do it right, but I'm irritated that the government set itself a deadline and then didn't meet it," Munneke said.

The AMA voted to seek changes in current law to delay implementation of the Medicare fee schedule resource-based practice expense relative values until January 1, 1999, to allow the national study to be used in developing the practice component. The AMA reaffirmed its policy calling for the development of a "methodologically sound resource-based approach to practice expenses for the Medicare RBRVS with all deliberate speed." The AMA Board of Trustees will provide a progress report at the 1996 AMA Interim Meeting.

Three-year Transition to Single Conversion Factor

After much debate, AMA surgeons and primary care physicians reaffirmed their support for a compromise reached last year that calls for a three-year transition to a single conversion factor. The AMA will press for a transition period starting on January 1, 1997, regardless of when Congress enacts changes to the Medicare payment system. Primary care physicians have long sought a single dollar conversion factor for all physician services, and they are growing increasingly impatient with the delays. Surgeons agreed to support the single conversion factor, but they sought a gradual phase-in period.

Despite arguments in reference committees and in the House of Delegates, primary care physicians and surgeons were able to reach compromises that unite the house of medicine. "We are all here together, trying to find a fair and equitable solution that will benefit the people we take care of, not to try to heap more ice cream on our own slice of the pie," said Munneke. • • • • •

More Highlights of AMA Annual Meeting

Restructuring Plan

AMA delegates approved a restructuring plan that will change representation in the AMA House of Delegates by expanding representation for specialty societies and exploring the possibility of adding seats for other groups.

Licensing Telemedicine

The AMA will recommend that states and their medical boards establish a license to practice telemedicine across state lines that would be available to out-of-state licensed physicians who wish to practice medicine regularly in that state.

Medical Savings Accounts

The AMA took the position that all full-time employees covered through the workplace should have the right to choose a medical savings account coupled with a catastrophic insurance policy.

Mandatory HIV Testing

In a close vote of 185-181, the AMA shifted its policy and endorsed mandatory HIV testing of all pregnant women and newborns. Although opponents argued that the policy change runs counter to the public health community's prevailing opinion, delegates were swayed by the availability of new and improved treatments. • • • • •

Medicare Payment Localities Reduced

Medicare's 210 physician payment localities would drop to 89 under rules proposed in the July 2 *Federal Register*. As a result, payments would rise 0.3 percent in rural areas and fall 0.1 percent to 0.2 percent in urban areas. Minnesota would not be affected by the changes because Minnesota is currently a single state payment area. • • • • •

Geographic Coalition Moves Forward

The Minnesota Medical Association called a meeting of the Geographic Coalition in Chicago June 24 to set a new strategy to correct the geographic inequities in Medicare reimbursement. The coalition of 35 state medical societies was co-founded in 1989 by the MMA and the Utah Medical Society to work together to achieve a fair Medicare reimbursement system.

At the meeting, held in conjunction with the American Medical Association Annual Meeting, Michael J. Murray, M.D., MMA president, asked: "Where do we go from here?" The overwhelming response from the 50 participants, who represented 16 of the coalition's 35 state medical societies, was that the Geographic Coalition should move forward with an aggressive campaign. The coalition established a steering committee of seven state medical societies, including co-founders Minnesota and Utah as well as Iowa, Nebraska, New Hampshire, Vermont, and Wyoming, to draw up an action plan.

Thomas Reardon, M.D., vice

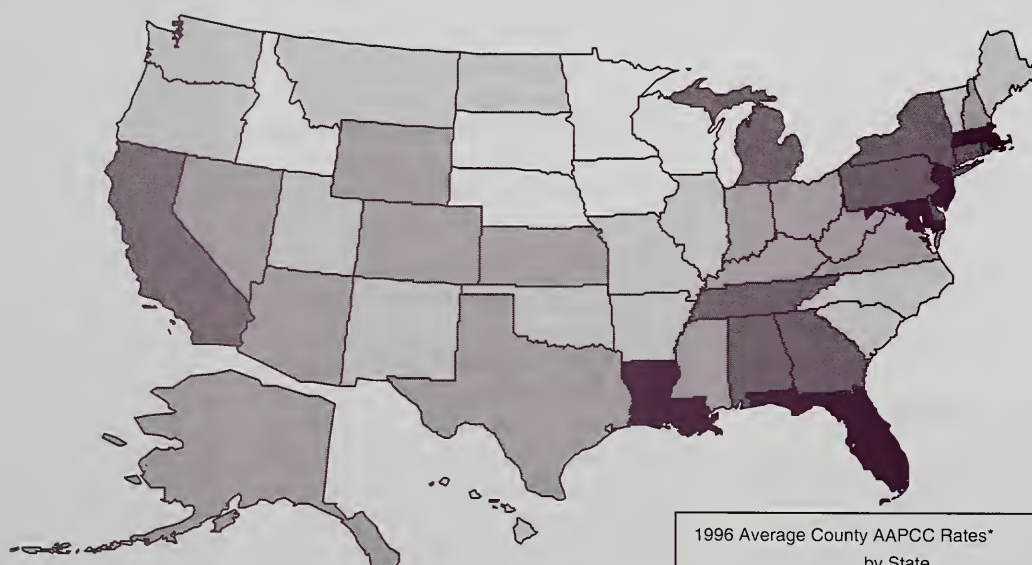
chair of the AMA Board of Trustees, encouraged the Geographic Coalition to continue to meet and to bring its message to the AMA House of Delegates. He offered the assistance of AMA staff but stopped short of promising AMA support for the coalition. Reardon said the AMA is in a tough position because achieving the goals of the Geographic Coalition would involve reducing reimbursement for other states. Although AMA policy tends to favor geographic equity, the political realities have kept the AMA from making it a top priority.

The coalition discussed several problems regarding Medicare reimbursement. Medicare fee-for-service reimbursement for physician services is based on the relative costs of three components: 1) work, 2) malpractice, and 3) practice. One of the main problems is that the practice component is based on historical Medicare charges, which vary widely depending on the geographic location. Minnesota, which has historically kept its charges low, is penal-

ized for past efficiency with a low reimbursement rate. The Health Care Financing Administration is trying to develop practice expense relative values based on the resources actually used, but its physician surveys won't be done in time to meet the deadline for implementation (see page 39). Another problem is that HCFA's study will do nothing to improve the practice component of the geographic practice cost indices, which are used to adjust the national average for differences in local payment areas.

The Geographic Coalition is also concerned that the inequities of the fee-for-service system have been carried over into managed care. Currently, the adjusted average per capita cost (AAPCC), the payment rate used in Medicare's risk contract program, reflects Medicare historical spending data. As shown in the map below, Minnesota's AAPCCs are at the bottom of the chart.

Members of the Geographic Coalition are determined to send the message to Congress and the Administration that it is not fair for Medicare reimbursement rates to vary widely throughout the country while all Medicare beneficiaries pay the same Medicare premiums. • • • • •



*US Average County Rate=\$377.24 (excluding Wash. D.C., Virgin Islands, Guam & Puerto Rico)

MINNESOTACARE NEWS

MEDPAC APPROVES AMPAC CONTRIBUTIONS TO MINNESOTA CANDIDATES

At a meeting of the MEDPAC Board, AMPAC representative Jean Hayes told the board that AMPAC will provide polling services valued at \$5,000 for 30 Congressional candidates before the primary. The MEDPAC Executive Committee recommended that AMPAC give the polling services to Democratic Minnesota Reps. David Minge and Collin Peterson because of their involvement in the Blue Dog Coalition, a group of conservative Democrats who have tried to forge a compromise on the federal budget. The MEDPAC Board also approved a recommendation that AMPAC make pre-primary contributions to Reps. Gil Gutknecht (R) and Martin Sabo (D). Previously, AMPAC contributed to Republican Rep. Jim Ramstad's campaign. The MEDPAC Board decided not to recommend contributions to candidates for the U.S. Senate at this time.

Currently, MEDPAC is in the process of endorsing candidates for the 1997 Minnesota Legislature. "The outcome of the November elections for all 201 seats in the Minnesota Legislature will determine MMA success next session. It is crucial for all MMA members to join MEDPAC," said John Dowdle, M.D., chair of the MEDPAC Board of Directors. To join MEDPAC, call Wendy O'Donnell at the MMA, 612/378-1875 or 800/999-1875.

MMA SEEKS REPEAL OF 2 PERCENT TAX

The MMA is laying the groundwork for an attempt to repeal or modify the onerous MinnesotaCare 2 percent tax on health care services. Currently, the MMA is testing the level of support from other groups and attempting to build coalitions.

In July, the MMA met with Michael Scandrett, executive director of the HMO Council, and Deb Seyfert, its director of policy and government affairs. The HMO Council agrees that a broader-based funding source would be appropriate but is not convinced that changing it is politically "doable." If it's not possible to change the funding source, however, Scandrett said the HMO Council will look for ways to make the pass-through work better. Many physicians are frustrated with the practice of some HMOs of claiming the pass-through has already been built into physician fees rather than paying it separately.

The MMA also met with Duane Benson, executive director of the Minnesota Business Partnership, to sound out the business community on support for MMA efforts to modify or eliminate the 2 percent tax.

The MMA will continue to meet with other groups and seek to form coalitions. With a surplus of \$300 million expected in the health care access fund by 1999, the MMA is arguing that the 2 percent tax should be phased out. The makeup of the new Legislature will be an important factor in determining whether the MMA can be successful. The MEDPAC Board is basing its endorsements for the 1996 elections largely on the candidates' position on the 2 percent tax.

Subcommittee on Health. Jacott recommended that the federal government take the following action:

- Create a new public/private task force to make recommendations about the need for a physician workforce and the funding of GME. The task force should consider such things as specialty mix, geographic distribution, and appropriate training.
- Restructure GME funding into an all-payer system. Since patients covered by all forms of insurance benefit from trained physicians, all payers should contribute to the cost of training physicians. GME funds should be distributed to the entity that incurs the costs of training, whether it be a medical school, hospital, nursing home, or ambulatory clinic.
- Analyze the current indirect medical education adjustment to assess how to develop an appropriate funding mechanism to reimburse teaching hospitals for the burden of increased complexity of care and severity of illness and disproportionate share.
- Reduce the number of GME positions gradually over a period of several years, considering the recommendations of the public/private task force on the physician workforce and medical education financing.

DR. JACOTT TESTIFIES ON GME FINANCING

William E. Jacott, M.D., head of the Department of Family Practice at the University of Minnesota Medical School and a member of the AMA Board of Trustees, recently testified on Medicare's financing of graduate medical education before the U.S. House Ways and Means Committee

DR. WILLETT APPOINTED TO BMP

Gov. Arne Carlson appointed Joseph R. Willett, D.O., to the doctor of osteopathy position on the Minnesota Board of Medical Practice, replacing David Kidder, D.O. Willett is a partner at Affiliated Community Med Centers and Chief of staff at Weiner Memorial Center in Marshall.

ANNOUNCEMENTS

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**MMA MEMBERS NEEDED
FOR RCB 5**

There is a vacancy for an MMA-appointed member and alternate to Regional Coordinating Board 5, which covers the entire MMA southwest trustee district. If you are interested in serving on RCB 5 or in nominating another physician, please call Steven Jahn at 612/378-1875 or 800/999-1875. Nominations are due by September 3. The MMA Board of Trustees will consider nominations at its September 18 meeting.

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**CONFERENCE ON
FAMILY VIOLENCE**

"Family Violence: Building a Community Response" will be held October 30 to November 1, 1996, in Oak Brook Illinois. This conference, an outgrowth of the 1994 National Conference on Family Violence, is sponsored by the American Medical Association, American Bar Association, U.S. Department of Justice, the U.S. Department of Health and Human Services, and other participating organizations. The conference will encourage communities to assemble multidisciplinary task forces to create coordinated antiviolence programs. Teams will consist of representatives from the fields of health, law, law enforcement, criminal justice, social services, and others. The registration cost is \$150. For more information, call Mark Vukelich at the MMA, 612/378-1875 or 800/999-1875.

New Law Requires Safe Storage of Firearms

Effective August 1, a new state law requires firearm owners to take "reasonable action" to prevent young people under age 18 from gaining access to stored firearms. The passage of this law as part of the Omnibus Crime Act was a victory for the MMA during the 1996 legislative session.

The MMA recommends that firearm owners unload and lock their firearms before storing them and that they store ammunition separately—especially in homes where children are present.

"Unload It & Lock It"

The Minnesota Medical Association has developed the brochure, "Unload It and Lock It," which includes specific recommendations on how to store firearms safely.

- Empty the ammunition from your firearm. Use a trigger lock, barrel lock, cylinder lock, a locking firearm case, or keep your firearm in a locked gun safe. Locking devices cost between \$7 and \$20; gun safes range in price from \$100 to \$1,000.

- Store ammunition separately in a locked container away from heat or moisture. Never throw ammunition in the trash.

- Carry the keys for the gun and the ammunition on your person at all times or keep the keys locked in a location known only to you.

- Never store a firearm on a bedside table or under a mattress or pillow.

- Do not store a firearm among valuables such as jewelry or silver where it might be stolen. Don't let your gun be used to commit a crime!

The MMA brochure was funded by Allina Health System, Blue Cross and Blue Shield of Minnesota, and HealthPartners, and it was endorsed by Attorney General Hubert H. Humphrey III, the Department of Natural Resources, the MMA, and the MMA Alliance.

Now that the new law has taken effect, this brochure will be especially helpful for your patients—especially those with children. To obtain brochures, call Beth Hoheisel at 612/378-1875 or 800/999-1875. The brochure can also be used as a poster in your waiting room. • • • • •

Health Plan Coverage Committee Seeks Information

The Governor's Task Force on Violence as a Public Health Problem, which includes MMA representative Andrew J. K. Smith, M.D., has convened a temporary work group to examine health plan coverage, reimbursement policies, and requirements and to consider whether changes would result in more effective treatment, intervention, and prevention.

The work group on health plan coverage has requested three things:

- 1) Volunteers or nominees to serve on the committee;

- 2) Background information including articles and publications on the topic of health plan coverage and payment policies relating to violence; and

- 3) Suggestions for specific topics, issues, and proposals to be considered by the new committee.

You may mail or fax information to Michael Scandrett at the Minnesota Council of HMOs, 2550 University Avenue West, Suite 255 South, St. Paul, MN 55114, or fax to 612/627-4655. • • • • •

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LEGISLATIVE NEWS

AG'S OFFICE EASES CONCERNS OF MEDICAL REVIEW BOARD

Fear of individual liability has been a major concern for physician members of the Department of Public Safety's Medical Review Board. Medical review board members review the medical histories of people who have appealed the denial of their driver's license, and reviewers then make recommendations to the commissioner of public safety. Fear of a lawsuit has not only been a concern for the reviewers, but has also made recruitment difficult.

At a recent meeting of review board members hosted by the MMA, Department of Public Safety staff revealed an opinion from the Attorney General's office that review board members are "acting on behalf of the state in performance of duties or tasks lawfully assigned by competent authority," and therefore, under the Tort Claims Act, the state will "defend, save harmless, and indemnify" them in case of a lawsuit. The AG's letter adds that the act "does not apply in case of malfeasance in office or willful or wanton actions or neglect of duty."

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REQUESTS FOR SURCHARGE EXEMPTION ARE DUE

Physicians who are eligible for an exemption from the Minnesota physician license surcharge must apply by September 1, 1996, if they pay for their license from April 1, 1996, through September 30, 1996. Previously exempted physicians must apply each year to maintain an exemption.

If you have an active Minnesota medical license, live in Minnesota or a border state, and have no outstanding unpaid previous surcharges, you qualify for an exemption if you meet one of the following criteria:

- You provide physician services at a free clinic, community clinic, or in an underdeveloped foreign nation and do not charge for any physician services;
- You are taking a leave of absence from the practice of medicine for at least one year and intend to return to the practice in the future and you do not charge for physician services or practice medicine;
- You are unable to practice medicine because of a terminal illness or permanent disability as certified by an attending physician and you do not charge for physician services or practice medicine;
- You are unemployed and you do not charge for physician services or practice medicine;
- You are retired and you do not charge for physician services or practice medicine.

Any remuneration for work that requires possession of a medical license disqualifies the physician from the surcharge exemption.

If you have any questions, call Patricia Franklin at the MMA, 612/378-1875 or 800/999-1875.

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NONPROFIT CORPORATION ALERT

Nonprofit corporations are required to register with the Office of the Secretary of State once each calendar year. An annual registration form can be filed at any time during the calendar year. You can obtain a form by calling the Business Information Phone Line at 612/296-2803 between 8 a.m. and 4:30 p.m. If the annual registration is filed once each calendar year, no fee is required. Corporations that have missed a year will owe a \$25 reinstatement fee. Failure to file will result in a notice of pending dissolution, after which

the corporation will be administratively dissolved.

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VOLUNTEERS NEEDED FOR MARROW DONOR EDITORIAL PANEL

The National Marrow Donor Program is developing a WebSite to give physicians and patients more information about the role of bone marrow transplantation in the treatment of disease. Currently, the NMDP is seeking volunteer physicians to serve on an editorial panel that will screen the content of the WebSite that will be geared to referring physicians in the fields of hematology/oncology, internal medicine, pediatrics, and general practice. If you are interested in this project or if you have any questions, call Pam Robinett, assistant director of transplant and collection services at the National Marrow Donor Program at 612/627-5814.

The Monitor

AUGUST 1996

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A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

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1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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Immunization Audits and Protocols

Valuable Tools to Improve Rates

The Shots for Tots project recommends that clinics audit charts and implement protocols to boost age-appropriate immunization rates.

Kristin Stets, R.N., M.P.H., Peter Harper, M.D., M.P.H., and Raymond Christensen, M.D.

Editor's Note: *It's immunization time again. As preschoolers come in to complete immunizations, remember to ask about the immunization status of other family members. Beginning this fall, all seventh- and 12th-graders must have a dT immunization within five years of the first day of school. While the teens are there, consider beginning the Hepatitis B series that is now recommended for all adolescents who did not receive the series as infants. And don't forget to take full advantage of the early-season sports physicals and precollege exams to check the immunization status of older teens and young adults. Immunizations are our most effective preventive health measure.*

Watch for the September Public Health Report on how to obtain and use the tool CASA to assess your clinic's immunization rates.

—Barbara P. Yawn, M.D., M.Sc.
Series Editor

Immunizations against preventable diseases such as measles, mumps, polio, and whooping cough (pertussis) have long been considered one of the most important preventive health measures available today. It is difficult to exaggerate the value of vaccines. With the exception of clean water, few other public health interventions have had such a major impact on mortality and population growth. In addition to protecting children from unnecessary diseases that may have serious consequences, vaccines are cost-effective. For every dollar invested in immunization programs, \$10 is saved in medical costs to treat disease and illness.

Although more than 95% of U.S. children are fully immunized by the time they reach kindergarten (a requirement in all 50 states), infants and toddlers are not adequately protected. In Minnesota, 98% of children are fully immunized by the time they reach kindergarten, but a 1992 Minnesota Department of Health study revealed that only 61.4% of 2-year-olds are appropriately immunized.¹ The Surgeon General's goal is to increase the immunization rate for 2-year-olds to 90% by the year 2000.

Shots for Tots, a project of the Children's Defense Fund—Minnesota, recommends that clinics audit their charts to determine immunization rates and to implement protocol changes to boost the rate of age-appropriate immunizations. Through its recent research, the Shots for Tots project has found that these measures can effectively increase immunization rates.

SHOTS FOR TOTS PROGRAM

To improve the immunization rates of Minnesota's preschoolers, the Children's Defense Fund—Minnesota created Shots for Tots, a collaborative project involving experts and agencies from around the state. The first phase of the project was to collate current information on effective Minnesota programs that immunize preschool children.

The "Shots for Tots Best Practices Report" was released in May 1994. A key finding was that clinics can significantly raise their immunization rates by eliminating missed opportunities to immunize children. According to Walter Orenstein of the Centers for Disease Control and Prevention, "Missed opportunities reduce immunization coverage by 10 to 15 percentage points."²

IMMUNIZATION AUDITS

To implement the Shots for Tots best practices, the Children's Defense Fund recruited clinics to complete audits. Before the audits, clinic staffs were asked to estimate their clinics' immunization rates. The perceived rates were much higher than actual rates. The audits provided baseline information and increased awareness of the problems.

Five clinics in greater Minnesota participated in the audit project. Each clinic followed a three-step process:

- 1) Audited immunization status of their 2-year-olds;
- 2) Implemented changes if needed to improve rates; and
- 3) Conducted another audit six months later to de-

termine whether rates had improved.*

The clinics reviewed the charts of 24- to 36-month-old patients who had three visits to the clinic, including one visit in the last year, to determine the percentage of these patients who had been age-appropriately immunized with the primary series (four DPT, three OPV, one MMR).

In the first audit, the clinics' immunization rates ranged from 33% to 89% for 2-year-olds. The repeat audit showed an improvement, with immunization rates ranging from 62% to 92% (see Figure 1). The EastSide Health Coalition of St. Paul, which serves an inner-city population, also conducted a series of audits in local clinics. Their results showed improvement with the

audits (see Figure 2).

The participating clinics considered the audits a valuable experience. Following are some of the comments we received from their staffs:

- "Reviewing immunizations can identify other pertinent health issues of the client."
- "An under-immunized child is often an under-assessed child."
- "Involving staff in the audit process facilitates ownership of clinic immunization rates."
- "Chart audits improve staff awareness of immunizations and, thereby, improve rates."
- "Audit results can easily be translated to meet requirements for third-party payers."

Figure 1

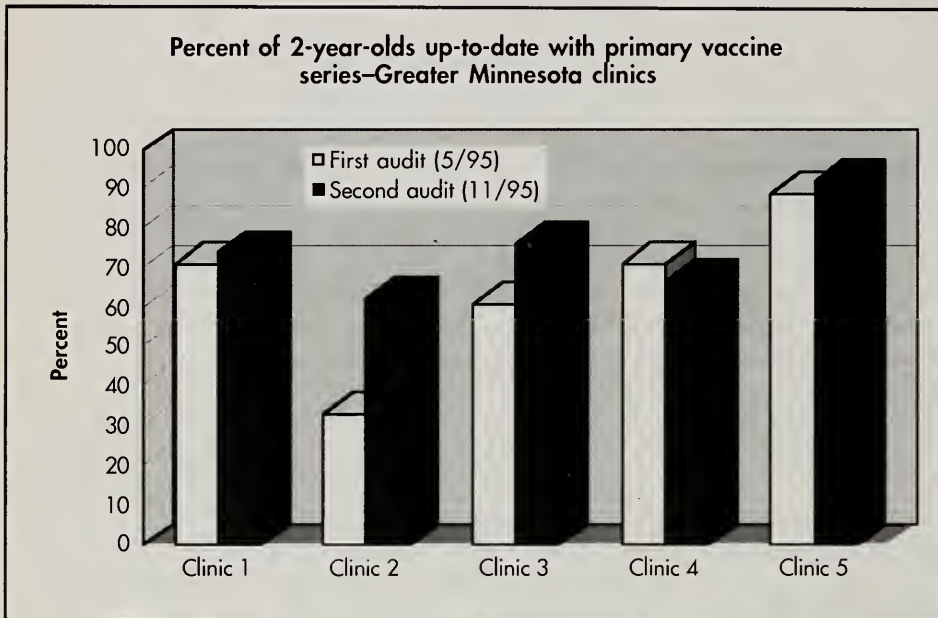
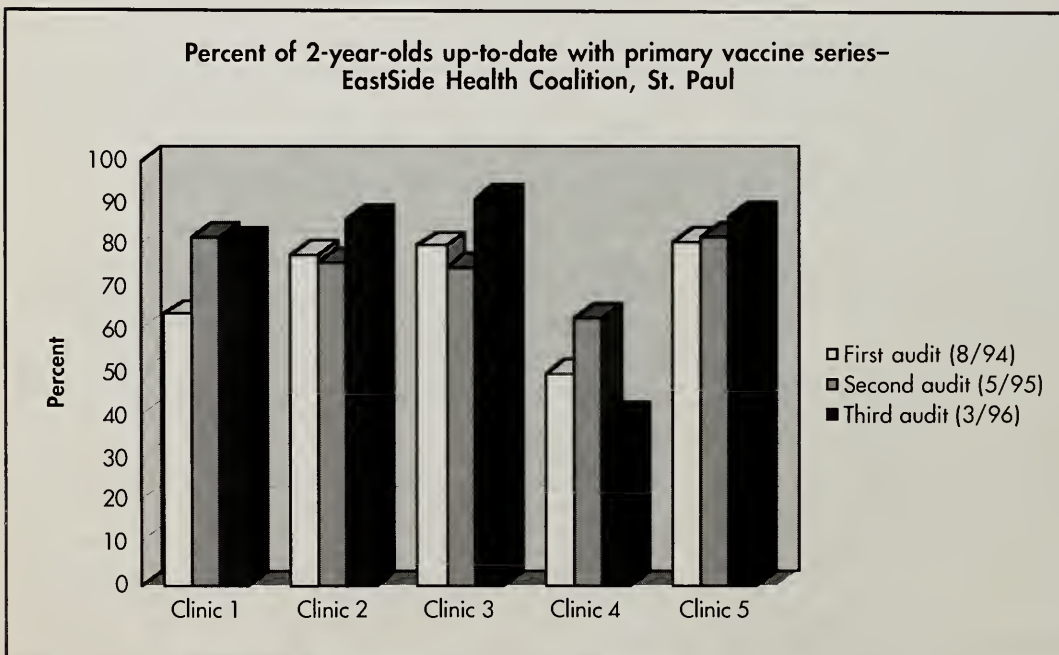


Figure 2



IMMUNIZATION PROTOCOLS

In response to the audits, physicians, nursing staff, and receptionists decided the most effective way to eliminate missed opportunities and improve clinic immunization rates is to assess patients' immunization status at every visit. The clinics are using the following protocols:

1. A check-box on the shingle, chart flow sheet, or progress notes asking, "Immunization up-to-date?"
2. A Post-it® note on billing sheet or flow sheet asking, "Immunization up-to-date?"
3. A stamp on the chart asking about immunization status.
4. A "No missed opportunities protocol" that requires every staff person who encounters a patient to ask certain questions regarding immunization status.

Many clinics also implemented tracking and reminder systems to encourage parents to bring their children to the clinic for immunizations.

*The National Vaccine Advisory Committee of the U.S. Public Health Service, Centers for Disease Control and Prevention, Department of Health and Human Services, recommends providers conduct semi-annual audits to assess immunization coverage levels.

CONCLUSION

The Children's Defense Fund-Minnesota along with the Minnesota Department of Health and physicians across the state are urging all clinics to audit their charts to determine their patients' immunization rates and to implement protocol changes to boost the rate of age-appropriate immunizations.

MM

ACKNOWLEDGMENT

Shots for Tots, a project of the Children's Defense Fund, gratefully acknowledges the Allina Foundation for its funding and support of this project.

For more information on audits or a copy of the "Shots for Tots Best Practices Report," please contact the Children's Defense Fund-Minnesota at 612/227-6121.

Kristin Stets is a consultant for the Children's Defense Fund and coordinator of the Shots for Tots project. Peter Harper is a family physician in St. Paul and also works with the EastSide Health Coalition. Raymond Christensen is a family physician in Moose Lake and president-elect of the Minnesota Medical Association.

REFERENCES

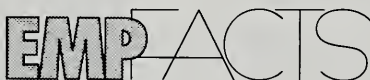
1. Minnesota Department of Health. The Minnesota Immunization Action Plan Disease Control Newsletter 1993;21:58-60.
2. Orenstein W. Vaccine preventable disease in the '90s: a national perspective. Presented at: Strengthening core functions: future roles for state and local public health (Minnesota Department of Health conference on vaccine preventable diseases). 5 April 1994; Minneapolis.



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munications Association, Minnesota Hospital and Healthcare Partnership, Minnesota Nurses Association, Minnesota Council of HMOs, Center for Reducing Rural Violence/Citizens Council, Allina, Blue Cross and Blue Shield of Minnesota, HealthPartners, Citizens for a Safer Minnesota, Ramsey Medical Society, Hennepin Medical Society, and growing.

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People and Places Making Medical News

P e o p l e

'U' Interim Medical School Dean

Alfred Michael, M.D., a professor and Pediatrics Department chair, has been appointed interim dean of the University of Minnesota Medical School effective immediately. He will remain interim dean while the university conducts a nationwide search for a permanent replacement for Frank Cerra, M.D., who became provost of the university's Academic Health Center in April after former Provost William Brody, M.D., Ph.D., was appointed president of Johns Hopkins University in Baltimore. Michael, known internationally for his research and treatment of kidney disease, joined the university in 1960 as a post-doctoral fellow. He will continue to head the Pediatrics Department while serving as interim dean.

HCMC's Bluford Resigns

John W. Bluford, administrator of Hennepin County Medical Center, is resigning his post effective September 6 to accept a position as senior vice president/chief operating officer at Boston Medical Center in Boston, Massachusetts. Bluford has been HCMC administrator since August 1993. He founded Metropolitan Health Plan, Hennepin County's health maintenance organization, and has served as its executive director since its inception in 1983. Prior to 1993, he held positions as HCMC's deputy administrator, HCMC associate administrator, and administrator of Pilot City Health Center dating from 1977.

Boston Medical Center is a private, nonprofit, full-service

teaching and research hospital affiliated with the Boston University School of Medicine. It is a new entity formed by the merger of Boston City Hospital, Boston Specialty and Rehabilitation Hospital, and Boston University Medical Center Hospital.

HealthEast, Allina Integrate, Appoint New Director

James M. Reimann has been named executive director of the integrated health care delivery system (IHDS) that HealthEast and Allina Health System recently formed to serve patients in the eastern Twin Cities metropolitan area. Reimann will be responsible for the development, implementation, and daily operation of the IHDS, including strategic planning, budgeting, network development, and representation of the IHDS to physicians, employers, and health care consumers.

Formerly, Reimann was director of network services for Allina Health System. He joined Medica Health Plans in 1994 at the time Medica and HealthSpan merged to form Allina. Before that, Reimann was employed by HealthPartners and was involved with the integration of Group Health and MedCenters.

The integration of HealthEast and Allina is not a merger, but allows the groups to jointly manage health care quality, costs, and access. The agreement is nonexclusive, which gives HealthEast, Allina, and participating physicians flexibility to negotiate contracts with other providers or health plans.

Distinguished Clinician Award

Arnold P. Kaplan, M.D., a founding partner of Minnesota Gastroenterology, received the American Gastroenterological Association's

Distinguished Clinician Award at its annual meeting in San Francisco. The award, given to five U.S. gastroenterologists, recognizes Kaplan's outstanding leadership skills and progressive community-based patient care.

Kaplan, who has practiced medicine in the Twin Cities for the past 30 years, developed the first community hospital-based endoscopy center and laboratory at the former Mt. Sinai Hospital in Minneapolis, where he served as medical director of the Colon Center. He was one of the first physicians in private practice to create a community-based screening program for colon cancer. A founder of Digestive Healthcare, P.A. (now a division of Minnesota Gastroenterology), Kaplan specializes in colon cancer prevention and diagnosis, colonoscopy, esophageal disease, and laser treatment for gastrointestinal lesions. He is also a clinical professor of medicine at the University of Minnesota.

Neurologic Society Officers

Joanne B. Rogin, M.D., has assumed the presidency of the Minnesota Society of Neurological Sciences. She is a neurologist with the Minneapolis Clinic of Neurology and medical director of the Midwest Center for Seizure Disorders.

Other newly elected officers are David C. Anderson, M.D., Minneapolis, vice president, and Barbara Patrick, M.D., St. Paul, secretary-treasurer.

MPS President-Elect

Joseph Westermeyer, M.D., of St. Paul has been chosen president-elect of the Minnesota Psychiatric Society (MPS). Westermeyer, chief

of psychiatry at the Veterans Affairs Medical Center in Minneapolis, has long been active in MPS, serving previously as president in the mid-'80s. Westermeyer has a strong interest and international reputation in cross-cultural psychiatry and cross-cultural addiction medicine.

Other MPS officers elected include **Rick Immler, M.D.**, St. Paul, member of council, and **Joyce Tinsley, M.D.**, Rochester, member of council. **Judith Kashtan, M.D.**, Minneapolis, is the current president.

HealthPartners Director

Richard J. Gray, M.D., has been appointed director of cardiovascular services at HealthPartners. In his new position, Gray will lead HealthPartners and Ramsey cardiology group practice and develop the HealthPartners Center of Excellence for cardiovascular care at Ramsey. Before joining HealthPartners, Gray served as chair of the Department of Internal Medicine in the School of Medicine, University of North Dakota, Grand Forks.

Duluth Clinic Chief Officer

Mary Johnson, R.N., M.S., has been named chief operating officer for Duluth Clinic. In her new position, Johnson will manage all operations within the clinic. Formerly, she was administrator of clinical operations, and before joining Duluth Clinic in 1994, she served as director of clinical services—ambulatory care at the University of Wisconsin Hospital and Clinics in Madison.

Allina Network Services VP

Allina Health System has hired **Susan Garrison** to serve as vice president of network services. She will be responsible for the development of Allina's network strategy

and services. Over the past 20 years, Garrison has worked in the integrated health care environment focusing on continuous improvement and physician/health plan partnership.

Garrison has worked as an independent consultant for the past year, most recently as project leader for redesigning the physician network of a large super IPA in Connecticut. Before that, she was vice president of operations for the Ohio region of Kaiser Permanente.

FPA VP and Board Members

Fairview Physician Associates (FPA) has appointed **Steven Housh** vice president of operations. Housh has served as administrative director of FPA since 1993 and has worked in the Twin Cities health care industry for the past 10 years.

FPA also has elected the following five members to its board of directors: **John Canfield, M.D.**, family practitioner with France Avenue Family Physicians; **Loie Lenarz, M.D.**, family practitioner with Lagoon Family Health Care; **Edward Lindell, M.D.**, executive vice president—external affairs for Lutheran Brotherhood; **Paula Roe**, vice president and director of compensation and benefits at Norwest Banks; and **James Smiley**, vice president—Minnesota for US West Communications.

HealthSystem Minnesota Board Members

HealthSystem Minnesota has elected four new members to serve on its board of directors: **Jane A. Brattain**, a homemaker and active volunteer at St. Martin's Episcopal Church and Breck School; **Gary A. Coon, M.D.**, medical director of Methodist Hospital's Department of Emergency Medicine and president of the Methodist Hospital medical staff; **A. Stuart Hanson, M.D.**, president and chief executive officer of the Institute for Research and Education HealthSystem

Minnesota, a former president of the Minnesota Medical Association, and an internist who specializes in pulmonary medicine at Park Nicollet Clinic; and **Michael Johnson**, president of The Foundation HealthSystem Minnesota.

Places

Allina Teams Up With IBM and MedicaLogic

Allina Health System has formed a new partnership with IBM and MedicaLogic to expand Allina's use of electronic information.

Allina and IBM are creating "Allina HealthVillage" a customized, on-line network service on the Internet that will offer electronic information, such as answers to general questions on health care and information and resources tailored to individual members of Allina's Medica Health Plans.

MedicaLogic, a medical software firm based in Beaverton, Oregon, will work with Allina to help its hospitals, clinics, and health plans integrate computerized medical records. The new system, which will be used primarily by physicians and other health care providers, will include chronological records of each patient's clinic visits, past and present prescriptions, early detection screenings, and lab results.

The Allina HealthVillage is an Internet application that, among other things, will allow customers to access information on quality, service, and costs regarding Medica's provider network; schedule appointments with Allina-affiliated health care providers; and review and enroll in classes and seminars sponsored by Allina hospitals. In addition, users will be able to access a number of other resources, such as an on-line library to research information on health care topics; a wellness center that will provide interactive

resources about fitness, nutrition, and health assessment; and a government center that will provide updates on local, state, and national health programs, health alerts, and immunizations.

AGPA/UMGA Merge

The board of trustees of the American Group Practice Association and the board of directors of the Unified Medical Group Association have merged to form the American Medical Group Association (AMGA). Their combined agenda focuses on quality integrated health care that allows physicians to make decisions. AMGA, which represents more than 350 of the nation's leading group practices and physician-owned and managed IPAs, will maintain offices in Alexandria, Virginia, and Seal Beach, California.

"The merger of these two organizations provides group practice and managed care physicians with a strong, comprehensive platform from which they can shape the U.S. health care marketplace and ensure high-quality, cost-effective patient care," said James L. Reinertsen, M.D., president of AMGA and president and chief executive officer of HealthSystem Minnesota.

'U' Program to Bring More People into Health Care Decisions

Through a three-year study, the University of Minnesota hopes to widen the range of people who make decisions about community health care systems. The study, funded by an \$839,000 grant from the W.K. Kellogg Foundation and awarded to the university's executive study program for health care administration, will examine how health care can be managed in the face of new technology, how community needs can be identified and addressed, and how resources can be used cost-effectively.

"There is a growing demand for city managers, school boards,

and corporate leaders to share in a decision-making partnership with traditional health care organizations such as hospitals, HMOs, insurers, and physicians," said Mary Jane Madden, assistant professor in the School of Public Health and principal investigator of the study. "The Health System Leadership Program will develop a model for communities to establish those partnerships," she said.

Ob/Gyn Practice Relocates to Arden Hills

The northeast Minneapolis office of Fairview Riverside Ob/Gyn & Nurse Midwifery, formerly known as Professional Obstetrics & Gynecology, is now located in the Arden Plaza building at 3585 Lexington Avenue North in Arden Hills.


The new clinic office includes a room for special procedures, a patient education room, and a

children's play area. Fairview Riverside Ob/Gyn & Nurse Midwifery joins Arden Hills Family Physicians, also a Fairview clinic, and Fairview Home Care and Hospice at the Arden Hills site.

Allina Awards Second Quarter Grants

Allina has awarded a \$298,040 grant to the Minnesota Family Strength Project and a \$110,220 grant to the River Falls Healthy Communities Team in River Falls, Wisconsin. The goal of the grants is to support projects that will engage citizens and change systems to improve community health.


The Minnesota Family Strength Project plans to identify the connections between systems that contribute to family functioning and health status. The 15-month project hopes to find ways to better



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integrate family and health services and to create educational strategies for helping families. The project is led by Family and Children's Service and also involves Minnesota Public Radio, the Minnesota Historical Society, and Medical Health Plans.

The River Falls Healthy Communities Team is organizing a community-wide adolescent alcohol use prevention project. The project targets adolescents, parents, and the community to help reduce adolescent alcohol use, which has increased in the River Falls community. The initiative will increase recreational and educational after-school activities for adolescents, develop a monitored after-school drop-in facility for youth, increase volunteer and employment opportunities for youth, provide forums for youth to speak to adult community members about their needs,

and educate parents about adolescent alcohol use.

AHA-Minnesota Names Research Awardees

The American Heart Association-Minnesota Affiliate in May awarded \$934,263 to 39 Minnesota researchers representing five institutions. For the 1996-97 year, the University of Minnesota-Minneapolis produced 23 award winners, who received a total of \$554,312. Mayo Clinic received 12 awards for a total of \$287,651. The remaining awards went to the University of Minnesota-Duluth (two awards totaling \$47,809); the Veterans Affairs Medical Center-Minneapolis (one award for \$20,518); and Hennepin County Medical Center-Minneapolis (one award in the amount of \$23,973). These awards are in addition to \$1 million in grants and fellowships the AHA's National Center allocated to support Minnesota research projects last year.

Hospice Center Reopens in Twin Cities

Hospice Preferred Choice, Inc., has resumed operation of its hospice program in the Twin Cities. It suspended operations in February following a budget-related freeze on initial Medicare certifications for health care providers. Medicare certification, administered by the Minnesota Department of Health, is required for health care providers who serve Medicare patients.

After the well-publicized certification freeze, which affected many home care and hospice programs, the Minnesota Legislature passed legislation allocating \$200,000 to conduct initial Medicare surveys from July 1, 1996, to June 30, 1997.

Edina-based Hospice Preferred Choice provides hospice care in private residences and in long-term care facilities in the 11-county metropolitan area. It is a subsidiary of Beverly Enterprises based in Fort Smith, Arkansas.

Socioeconomics

Fairview, University Hospital Hammering Out Merger Details

As *Minnesota Medicine* goes to press, the University of Minnesota Board of Regents is considering a detailed proposal to merge University Hospital with Fairview Health System. Under the plan, Fairview would own the University Hospital, but the hospital would continue to operate as a research and education center for the university's Academic Health Center.

The proposal calls for Fairview to pay \$87 million for the University Hospital, the hospital's parking ramp, and five university-owned clinics in Minnesota and Wisconsin and a community hospital in Hibbing, Minnesota. Fairview would control University Hospital's \$150.3 million in funds and would assume its liabilities of \$64.5 million.

Meanwhile, the University of Minnesota would invest \$20 million in the new hospital complex and would pay Fairview \$1 million per month for up to 32 months to cover the cost of physician education and research. During that time, the institutions would determine the actual costs of these services and would later split them evenly. In return for the university's investments, Fairview would contribute any amounts over 3.5 percent of the whole system's net earnings to education and research. The proposal also would give the university the majority of seats on the governing board of the new merged hospital complex.

The plan calls for University Hospital employees to become Fairview employees. About 10 percent of non-union University Hospital employees would get pay cuts, and about 5 percent would get pay increases to bring salaries to a level comparable with Fairview employees' salaries. The

merger would end all university contracts with union workers; Fairview and the university have not yet determined whether Fairview would recognize the existing unions.

As *Minnesota Medicine* goes to press, the Board of Regents is expected to vote on the proposal July 29.

State Expects Increase in Health Insurance Rates for '97

State officials predict that health insurance rates for state workers and their dependents will increase about 6 percent for 1997, the largest increase since 1992. The increase for 1996 was only 1.5 percent, and the previous year insurance rates dropped 1.7 percent. As Minnesota's largest single employer, the state provides benefits for about 57,000 employees and their dependents.

The 1997 hike is a combined rate increase from Medica, HealthPartners, Blue Cross and Blue Shield of Minnesota, and First Plan of Minnesota.

United HealthCare Stock Falls

Stock in Minnetonka, Minnesota-based United HealthCare Corp. fell 30 percent, from \$44.25 to \$31, on July 11 after the company announced that second-quarter earnings would be lower than expected. That entire week, HMO stocks had been shaky, and United was the third HMO company to announce lower quarter earnings.

The company attributed its lower earnings to increased medical costs, especially for pharmaceutical drugs. It reported that costs have risen 3 percent to 4 percent this year because doctors are spending more money treating patients and prescribing drugs. United also said it expected losses on two contracts in the St. Louis market that

MetraHealth negotiated before United took over the company last October. Earnings were also down because of a reported \$15 million in expenses related to United's recent acquisition of HealthWise America.

Allina and Wisconsin Hospitals/Clinics Discussing New Health System

Three clinics and three hospitals in Hudson, New Richmond, and River Falls, Wisconsin, have signed a letter of understanding with each other and with Allina Health System to begin discussions that could lead to the creation of a new regional health care delivery system. The clinics and hospitals are Hudson Physicians, New Richmond Clinic, River Falls Medical Clinic, Hudson Medical Center, Holy Family Hospital in New Richmond, and River Falls Area Hospital.

The letter of understanding commits each of the parties to a 120-day period of exploration and negotiation, during which time discussions will take place to create a collaborative approach to health care delivery in the communities represented. The system would not be exclusive but would leave room for participants to collaborate with others as well. The goals are to improve health care in the three communities, maintain stability for health care in the region, and provide competitively priced services that are locally driven and locally accessible.

Together the three hospitals are licensed for about 120 beds and admitted nearly 3,500 patients in 1995.

Innovations

Drug Pump Implant Available for Cerebral Palsy Patients

The Food and Drug Administration has approved for marketing in the United States Medtronic's implantable drug pump for treating

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice Internal Medicine Occupational Health

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

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612/785-3338



cerebral palsy and similar disabilities caused by brain injuries, according to a Twin Cities *Star Tribune* article. The pump delivers the muscle-relaxant baclofen directly to the spinal fluid. The drug pump is an alternative to rhizotomy, an operation that involves severing nerves in the spinal canal to allow muscles to relax.

It's estimated that the new therapy may help 30 percent to 40 percent of the 350,000 Americans who suffer from chronic muscle stiffness associated with cerebral spasticity and the 100,000 whose spasticity was caused by brain injury. Most of the patients treated in the FDA-required trials were able to move better, and some patients' speech and alertness improved. Side effects associated with the new therapy include sleepiness, nausea, headache,

muscle weakness, and lightheadedness.

The pump, which costs \$7,500, contains 3.5 teaspoons of the drug. It is refilled through a needle every one to three months. Implantation costs range from \$20,000 to \$25,000.

FDA Approves t-PA for Stroke Victims

The Food and Drug Administration has approved use of the clot-dissolving drug t-PA, sold by Genentech Inc. under the brand name Activase, to prevent permanent brain injury in stroke victims. The drug is widely used to treat heart attack victims.

The drug must be used within three hours of a stroke's onset or it

can trigger dangerous bleeding in the brain. The FDA approval gives Genentech the go-ahead to advertise t-PA to emergency rooms, rural doctors, and patients, educating them to recognize early signs of stroke and to understand the critical need for prompt treatment.

A follow-up study sponsored by Genentech is being conducted at 100 centers nationwide, including the University of Minnesota, Hennepin County Medical Center, and Abbott Northwestern Hospital.

Minntech Recalls Medical Device from Hospitals

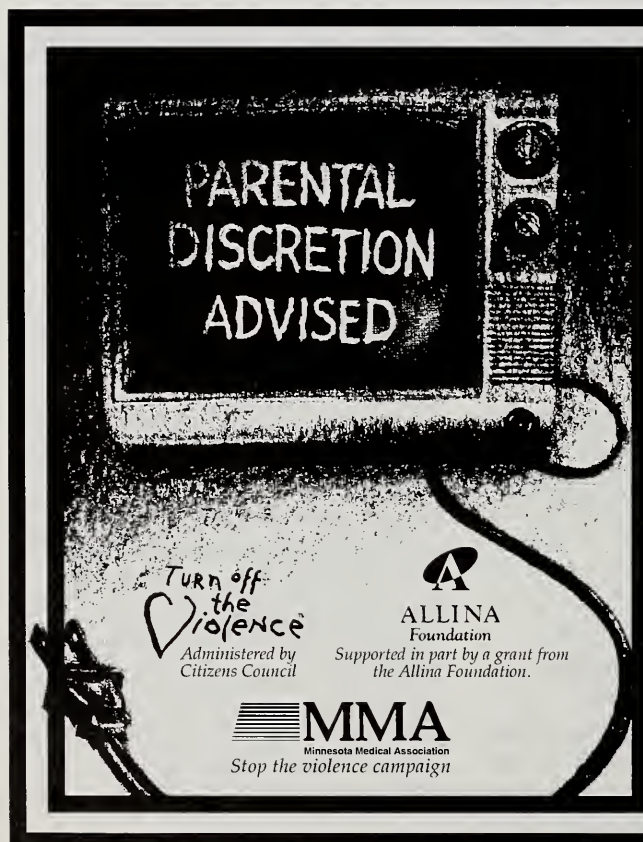
Plymouth, Minnesota-based Minntech Corp. has cautioned hospitals to stop using its Biocor

oxygenator after nine incidents of unexplained pressure drops during surgical procedures in the past nine months. None of the patients was injured.

The oxygenators are used mainly in Europe and Canada; the company is awaiting approval from the Food and Drug Administration for marketing the product in the United States.

The company said that the incidents affected fewer than 1 percent of the patients treated with the Biocor oxygenator and that similar pressure drops have been reported with competitors' products. The company is examining the faulty oxygenators to determine what's causing the malfunctions.

MM



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612-378-1875

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

AUGUST 1996

Aug. 2-3 **Bleeding and Thrombosing Diseases: The Basics and Beyond** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Aug. 8-10 **Third Annual Symposium on Biomedical, Biopharmaceutical, and Clinical Applications of Capillary Electrophoresis** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Aug. 12-13 **Navigating NCQA Accreditation: An Introduction to NCQA's Standards and Review Process** National Committee for Quality Assurance (NCQA); Hyatt Regency, Minneapolis, MN. CONTACT: NCQA Education Department, 2000 L Street NW, Suite 500, Washington, D.C. 20036; 202/955-3530.

Aug. 16-17 **Point-of-Care Testing and Phlebotomy** Mayo Medical Laboratories; Swissôtel, Boston, MA. CONTACT: Julie McAdams, Mayo Medical Laboratories, Hilton 360, Rochester, MN 55905; 800/533-1710.

Aug. 18-20 **Success With Failure: New Strategies for the Evaluation and Treatment of Congestive Heart Failure** Mayo Foundation; Vail Cascade Hotel & Club, Vail, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Aug. 24 **Phacoemulsification Course** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Aug. 24-27 **International Symposium on Radioiodine** Mayo Clinic/Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

SEPTEMBER 1996

Sept. 9-10 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT:

Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Sept. 12-14 **Practical Surgical Pathology Conference in Honor of Louis H. Weiland, M.D.** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Kathy Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, Rochester, MN 55905; 800/533-1710.

Sept. 19-20 **Mayo Clinic Update in Hepatology and Liver Transplantation** Mayo Foundation; Hotel Sofitel, Minneapolis, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 19-20 **Sixth Annual Practical Pediatrics Course for the Primary Care Physician** Children's Health Care; Children's Health Care-St. Paul, MN. CONTACT: Mickey Starr, 345 North Smith Avenue, St. Paul, MN 55102; 612/220-6133.

Sept. 19-21 **Echocardiography for the Sonographer 1996: Focus on Myocardial and Valvular Disease** Mayo Clinic; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 21 **Current Concepts in Glaucoma** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

Videotapes: **Emerging Infectious Diseases** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 26-27 **Twenty-third Mayo Clinic Pediatric Days** Mayo Clinic; Radisson Plaza Hotel, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 29-Oct. 4 **Advances in Diagnostic Radiology and Advanced Radiology Life Support** Mayo Foundation; The Broadmoor Resort, Colorado Springs, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

OCTOBER 1996

Oct. 3-5 **Mayo Vascular Symposium 1996: Advances and Controversies in the Multidisciplinary Management of Vascular Disease** Mayo Clinic and North American Chapter of the International Union of Angiology; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Oct. 4 **Insights and Outlooks '96** St. Paul Heart Clinic; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440; 612/992-3826.

Oct. 6-11 **Laboratory Diagnosis of Fungal Infections** Mayo Medical Laboratories; Portland Marriott at Sable Oaks, South Portland, ME. CONTACT: Kathy Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Oct. 11 **Ophthalmic Plastics Course** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 11-12 **Advanced Life Support in Obstetrics** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 12 **Twentieth Annual Current Trends in Ophthalmology Symposium** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 14-16 **1996 International Meeting on ANCA and ANCA-Related Diseases** Mayo Clinic and Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Kay Kenitz, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-8399.

Oct. 23-24 **Duluth Diabetes Conference** Duluth Clinic; Duluth, MN. CONTACT: Rockie Odberg, Medical Education Coordinator, 400 East Third Street, Fifth Avenue Building, Duluth, MN 55805.

Oct. 28-30 **Clinical Reviews 1996** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

NOVEMBER 1996

Nov. 4-5 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Nov. 9 **Minnesota Society of Pathologists Annual Fall Anatomic Pathology Conference With Steve Silverberg, M.D.** Minnesota Society of Pathologists; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Jennifer Nelson, MSP, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Nov. 11-13 **Clinical Reviews 1996** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 14-16 **Mayo Clinic Ob/Gyn Clinical Reviews** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 23 **Minnesota Society of Neurological Sciences Annual Meeting** Minnesota Society of Neurological Sciences; Radisson Plaza Hotel, Minneapolis, MN. CONTACT: Lisa Deminsky, 22732 132nd Avenue North, Rogers, MN 55374; 612/588-0661.

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- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Family Practice, Ob/Gyn to join progressive 14-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*2/96-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Olmsted Medical Center is seeking BC/BE physicians in the following specialties: emergency medicine and family medicine. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. Positions currently open include emergency room and family medicine departments in Rochester and branch office locations. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes nine branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (5/96-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine (oncology, pulmonology, and nephrology), family practice, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (8/96-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

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MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)



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Internal Medicine: The Fergus Falls Medical Group's five-member Internal Medicine Department is seeking a BC/BE general internal medicine physician as well as those with subspecialty training/interest in oncology, pulmonology, and nephrology. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066.

(9/95-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Occupational Medicine—Minneapolis: BC/BE occupational medicine physician needed to join the 14-member Occupational Medicine Department of a 400-physician multispecialty clinic in desirable Twin Cities area. We serve over 2,000 different client companies in the metro area. For additional information contact Patrick Moylan at 612/993-5986 or send CV and letter of inquiry to Professional Practice Resources, Park Nicollet Clinic HealthSystem Minnesota, 6500 Excelsior Boulevard, St. Louis Park, MN 55426; or fax 612/993-6490. *2-8/96

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To make application, please submit a letter of interest, a curriculum vitae along with three (3) references by September 30, 1996 to Dan Benzie, MD, Whiteside Search Committee, UMD School of Medicine, 10 University Drive, Duluth, MN 55812. (e-mail: mbeattie@d.umn.edu) or phone: 218/726-7574.

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Family Practice Opportunity on north shore—Lake Superior. Primary Care Clinic. Focus: wholeness, prevention, and education. Contact Jon Ward, Bay Area Health Center, 50 Outer Drive, Silver Bay, MN 55614; 218/226-4431. 3-8/96

AIM HIGH

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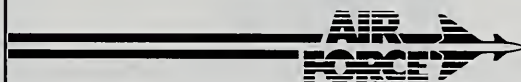
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Emergency Medicine Practice Opportunity: Beautiful, historic Red Wing. Coastal Physician Services offers low volume/acuity facility, flexible scheduling, guaranteed hourly compensation, no on-call, and procurement of professional liability insurance. For more information contact Ed Kennedy at 800/326-2782, or fax CV in confidence to 314/291-5152. *3-10/96

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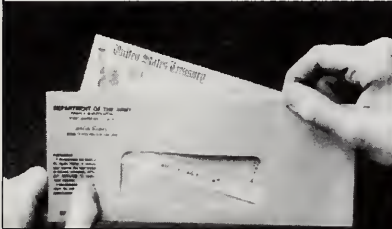


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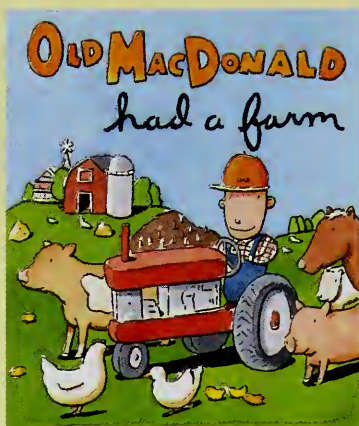
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FAMILY
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SEPTEMBER 1996



With the possible exception of Paul Bunyan, this may be Minnesota's most popular myth.

Old MacDonald's farm. It's a story most everyone knows. Unfortunately, it's also the perception many people have of



Farmers are developing broader uses for their commodities. Corn, for example, can be processed into 3500 different products.

today's farm. The reality, of course, is that there's far more involved in today's farm than a pig here and a chicken there.

Many people don't realize that today's farms

are the cornerstone of our state's economy.

That agriculture is Minnesota's largest industry. That it's responsible for 22% of Minnesota's economy and 22% of Minnesota's jobs.

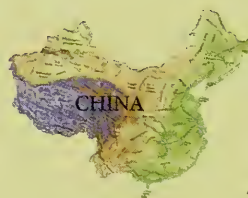
Today's farmers are among our state's most innovative business men and women. They constantly search for ways to further expand opportunities and the Minnesota economy. An increase of just 10% in agri-

Minnesota grain feeds livestock to help meet the world's growing demand for high-quality meat.



cultural exports would create 9,000 new jobs and generate about \$290 million of economic activity in the state.

Farmers expand manufacturing in Minnesota by pooling resources and forming joint ventures. Through these joint ventures, farmers develop processing plants that turn their raw materials into more valuable products.



From China to India to South America, Minnesota grains help feed one billion people around the world.

Raw corn is made into sweeteners and ethanol. Soybeans can be manufactured into plastics and diesel fuel. Wheat can be made into building materials. By processing raw commodities into finished, or value-added products, farmers expand their markets and our economy.

Livestock farming is valuable to Minnesota in the same way. The value to our economy of two acres of raw corn and soybeans is about \$740. When the corn and soybeans

are fed to hogs and the hogs are processed, the value is more than four times that.



Processing corn into sweeteners expands opportunities and our economy.

However, our farmers are careful not to pursue these

opportunities at the expense of the environment. In fact, Minnesota farmers adhere to some of the toughest and most strictly enforced environmental laws in the country.

Today's more dynamic Minnesota farms don't mean choosing between economic expansion and environmental protection. They mean a commitment to both.

And that means that while Old MacDonald's farm makes

for a nice little story, today's Minnesota farms may be that rare instance where the fact is more impressive than the fiction.



Processing grains into cleaner burning fuels could help reduce our dependence on foreign oil.



For more information on Minnesota agriculture, write MNAG2 at 14198 Commerce Ave. NE, Suite 600, Prior Lake, MN 55371, or visit our website at <http://www.mnag2010.com>

Minnesota Medicine

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COVER

Courtesy of the Norman Rockwell Museum at Stockbridge. © Curtis Publishing Co.

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The Guardians

What do the words water, white-water, phone, Iran, and file have in common? Add the word gate, and they become icons of deception and fraud. This



20th-century connotation has corrupted the more inviting sense of gates as entry points into something as appealing as heaven. So when today's family practitioners and other primary care doctors don the garb of a gatekeeper, they must ponder what the new title means. How does keeping gates fit with treating people? Does this

moniker change the family practitioner's role?

This month, *Minnesota Medicine* recognizes the 50th anniversary of the Minnesota Academy of Family Physicians and the installation of a family practitioner as president of the Minnesota Medical Association. It's a prime time to talk of these guardians of family health.

Our cover story (page 15) takes a historical look at family practice from World War II to the present. The profile of MMA's new president, Ray Christensen, M.D., describes a career that has spanned the wane of the old-time family practitioner and the wax of the new. And our Medicine Law and Policy articles examine the legal ramifications of physicians acting as gatekeepers (page 25) and supervising allied health professionals (page 29).

As heirs to centuries of GPs, today's family practitioners remain on the medical system's front lines. Medical problems generally are first heard, first seen, and first treated by family practitioners. As is true for most primary care doctors, FPs' relationships with their patients are almost more important than their knowledge of their patients' medical histories. But unlike other primary caregivers, FPs frequently know whole families. As Ray Christensen

relates, the FP-patient tie has always been long-term, high-touch, and patient-centered. And trust is the tie that binds.

How does this tradition mesh with gatekeeping? Gatekeeping in the current marketplace is the offspring of managed care cost-cutting failures. When utilization review, pre-admission screening, and payment withholds failed to control costs—when a deluge of MRIs, angiograms, scopes and scans overwhelmed even the most ingenious of bureaucratic clamps—the payers traced the patient's path back to the source and found that most of this expensive care entered the system through the doors of family practice clinics. What a great place to shut off the spigot!

So FPs in gatekeeping arrangements are supposed to make educated judgments about what services their patients need. They can allow or deny entrance to the medical system. Ideally, their decisions will be based on medical judgments only. But what if patients come with their own ideas about what they need? What if the payers start asking, "Why so many MRIs, Dr. Smith?"

The family physicians quoted in our articles refer repeatedly to being the patient's advocate, evoking the image of a defense attorney standing up for the patient against unfair disease and unjust systems. But gatekeeping seems to put the physician in the role of judge rather than defender.

Guarding the gates of heaven is Saint Peter, a holy figure holding the promise of eternal bliss beyond the pearly gates. At the entrance to Hades is another gatekeeper, Cerebrus, a multi-headed monster. Neither figure seems a good role model for physicians, though the realm beyond Saint Peter is certainly more alluring. To fulfill the gatekeeper's role and earn our patients' faith, physicians will need the soul of a saint and the sense of a sage. It's a tall order.

We don't need to witness a gatekeeper-gate. Caregiver, patient advocate, gatekeeper—whatever family physicians are called now and 50 years from now—they need to preserve what was lost with Watergate: trust.

—Charles Meyer, M.D., Editor-in-Chief

.....
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- Strategies in Primary Care, Holiday Inn East, St. Paul Nov. 14-15
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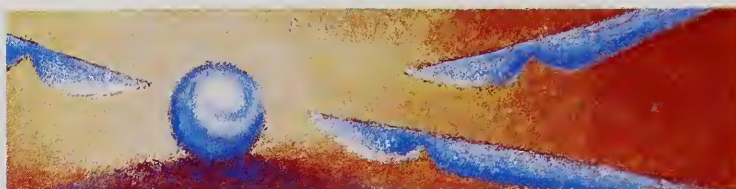
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I introduce the agent at the level of the metacarpal heads or distal palmar crease, directing 1cc to 2cc toward the radial and 1cc to 2cc toward the ulnar neurovascular bundles. I use a short, fine needle, usually 25 gauge. Addi-

tional anesthetic is injected on the dorsal aspect of the hand just proximal to the metacarpal heads directing most of the solution into the webspaces. This is where the dorsal digital nerves are most abundant. It is important to be patient; massaging the solution will help to dissipate the drug.

Testing the skin with the needle along the ulnar, radial, and dorsal aspects will ascertain whether additional local anesthetic is needed. It is important to add local anesthetic to cover only those areas that are sensate. It is not necessary to repeat the entire procedure.

Avoid injecting at the base of a digit, at the proximal flexion crease, since the volume of fluid plus any constricting dressing or a digital tourniquet can produce excessive hydrostatic pressure, which may lead to prolonged and even irreversible ischemia or nerve damage.

Submitted by Chris P. Tountas, M.D., a hand surgeon with Landmark Orthopedics, Ltd., in St. Paul.

Shoulder Injections for Subacromial Bursitis

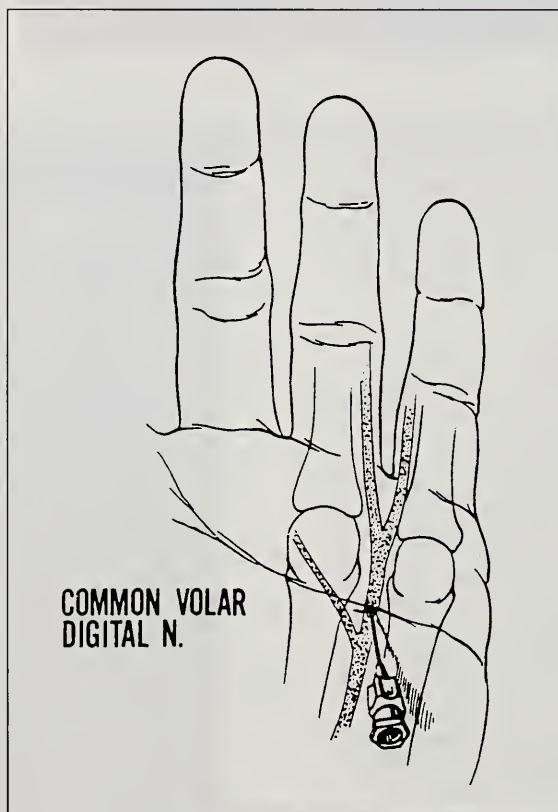
When injecting a shoulder for subacromial bursitis, or frozen shoulder syndrome, it is not uncommon for many physicians to inject the shoulder from an anterolateral approach. As we have learned from performing arthroscopy of the shoulder, there is less tissue in the posterolateral aspect of the shoulder, and, therefore, this is the preferred site of injection.

By simply feeling the tip of the acromion posteriorly with one's thumb and then moving 1cm medially and 1cm inferiorly, the "soft spot" can be palpated and an injection of steroids easily administered.

I typically use 3cc of Celestone, 3cc of 0.25% Marcaine with a 21-gauge, one and one-half inch needle. An injection of steroids in the shoulder administered in this fashion, with the needle tilted approximately 10 to 15 degrees superiorward, causes minimal discomfort.

Submitted by Jack Bert, M.D., an orthopedist with Landmark Orthopedics, Ltd., in St. Paul.

Send your "Pearls & Pointers" to Editor, Minnesota Medicine, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, or E-mail: mm@mnmed.org



Figure—Digital nerve block—palmar approach. Illustration by Elizabeth Roselius, ©1993. Reprinted with permission from Green DD, ed. Operative Hand Surgery. 3rd ed. New York, NY: Churchill Livingstone, Inc., 1993.

Correction

The August 1996 cover story, "Joining the Ranks of the Employed," incorrectly referred to Paul Spilseth, M.D., of Stillwater Medical Group as Bill Spillseth, M.D., on page 17. The editors regret the error.

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THE ADVOCATE

MMA's incoming president, Raymond Christensen, M.D., plans to promote patient advocacy and to strengthen MMA initiatives already in place.

BY JANE BRISSETT

It's the evening of a long day for Dr. Raymond G. Christensen, but he is not finished working. He saw about 25 patients at the Gateway Family Health Clinic Ltd. in Moose Lake today. Tonight he is on call at Mercy Hospital and Health Care Center, a 31-bed hospital and 94-bed nursing home where he serves as medical director. He will sleep in a tiny room marked "Doctor's Lounge," furnished simply with bed, easy chair, and desk.

Christensen, 52, is a man who doesn't waste a minute. He is down-to-earth and articulate but not verbose—a mix that serves him well as a family practitioner in a town of 1,400, where everyone knows him and his counsel is frequently sought.

As the Minnesota Academy of Family Physicians (MAFP) celebrates its 50th anniversary (see cover story, page 15), the incoming president of the Minnesota Medical Association is celebrating his own 25th year in family practice. The changes of the past quarter-century have markedly altered family practice. Once a slower-paced field of medicine made up of small clinics with one and two physicians, family practice now consists mostly of large group practices with a much greater reliance on technology, says Christensen, a past president of MAFP. In addition, supporting professionals, such as physician assistants, emergency medical technicians, and nurse practitioners, play a greater role in the medical community and have attained a significantly higher level of knowledge.

But the fundamentals haven't changed. Physicians need to attend to patients' physical, emotional, and spiritual needs and act as their advocates, says Christensen. "It's a very special privilege, and it's one we should never take lightly."

As Christensen assumes the presidency of the Minnesota Medical Association this month, promoting patient advocacy is a top item on his agenda. "Patient advocacy is physicians' No. 1 job, and that means making sure there's access to care and the care tree—that health care is available to everyone," he says.

"As the professional association for physicians, we need to assist our members in being patient advocates, providing a platform where they can bring patients' problems—problems that can't be solved in the clinic and that require policy or regulatory changes," says Christensen.

Twenty-five years ago, the physician-patient relationship was different, too. Back then, the physician was much more directive with regard to patients' care. Patients have assumed a much larger role in making decisions about their own



"Patient advocacy is physicians' No. 1 job, and that means making sure health care is available to everyone."

—Raymond Christensen, M.D.

University at River Falls. He was interested in reproductive physiology and originally intended to study veterinary medicine, until a talk with the dean about his future rekindled an earlier interest in becoming a physician.

After receiving his M.D. from the University of Wisconsin at Madison, Christensen took a rotating internship at St. Mary's Hospital in Duluth. From there, he moved to Moose Lake. What could have been an isolated life practicing medicine in rural Minnesota has for Christensen been an adventure in medical politics and regional medical activities. Among his many achievements, Christensen was a founder of the Rural Access

Clinic and the Northern Lakes Health Care Consortium, of which he is president. He is vice president of the Minnesota Center for Rural Health and a preceptor for the University of Minnesota Rural Physician Associate Program and the University of Minnesota–Duluth School of Medicine.

Christensen has been recognized for his work by the National Rural Health Association's 1989 Louis Gorin Award for Outstanding Achievement in Rural Health Care and the MMA's 1992 Community Service Award, among others.

Getting out of the goldfish bowl of small-town life is Christensen's way of renewing himself. "I found that when I left town, the yoke lifted," he says. Active in organized medicine, he has served on and chaired several MMA task forces. In 1993, he was elected MMA vice president and in 1995 was chosen president-elect.

Christensen believes the MMA is on the right track, and rather than introduce new initiatives during his term, he seeks to strengthen what has already been started. "I think right now we need to continue what we're doing, and we need to do it well," he says of the MMA.

The association's initiatives to end domestic violence, promote gun control, prevent drug and alcohol

medical care throughout Christensen's career, and he believes partnerships between the doctor and patient serve the patient's interests much better. "None of us has sufficient knowledge to make all the decisions for our patients," he says.

Christensen and Greg Peterson, M.D., founded Gateway Clinic in 1972. Their practice was built from scratch, and for three years they struggled financially. "There was a long stretch where 40 [patients] a day was usual," recalls Christensen, who was often on call two or three days in a row in the early days.

But like many family practice clinics in this time of change, the practice grew and hired more physicians, which allowed the original partners more freedom, but it also forced them to give up some control. Christensen and Peterson, who's no longer with the clinic, had difficulty adjusting in the beginning, but expanding the practice ultimately gave each partner a chance to pursue other interests and to take time off without worrying about how the others would fare shorthanded. "Once you get over the magic number of four [physicians], you've got it," says Christensen.

Christensen grew up on a farm in rural Wisconsin and earned a B.S. in agriculture from Wisconsin State

abuse, and educate parents, physicians, and the public about media violence and other matters have made important contributions to the health and welfare of Minnesotans, says Christensen, who plans to continue the organization's public health advocacy on these issues while he's president.

The organization also needs to look inward, to ensure that it is meeting the needs of all physicians. "Do we represent our membership and its needs? Let's open the debate," says Christensen. "How do we get our members more involved? A thought might be regional policy meetings to involve our membership."

A long-term goal for his presidency and beyond is to draw more doctors into the organization. "We need to make sure that the MMA remains attractive to physicians," he says. As increasing numbers of doctors are employed by managed care organizations and the profession becomes more diverse in terms of ethnicity,

gender, and specialty, organized medicine is challenged to meet the more disparate needs of its members.

But Christensen sees the challenge as an opportunity. The MMA is the one organization that can bring together *all* physicians in the state, providing a common ground for a profession with interests more diverse than ever. And Christensen points out that certain issues, such as patient advocacy and professional collegiality, remain important to physicians of all specialties, backgrounds, and health plan affiliations. "These issues can only be addressed by a broad-based professional organization such as the MMA," says Christensen. "With the incremental efforts of all of us as members and the dedication of our staff, the MMA will continue to meet the needs of patients, society, and the profession."

MM

Jane Brissett is a free-lance writer living in Duluth.



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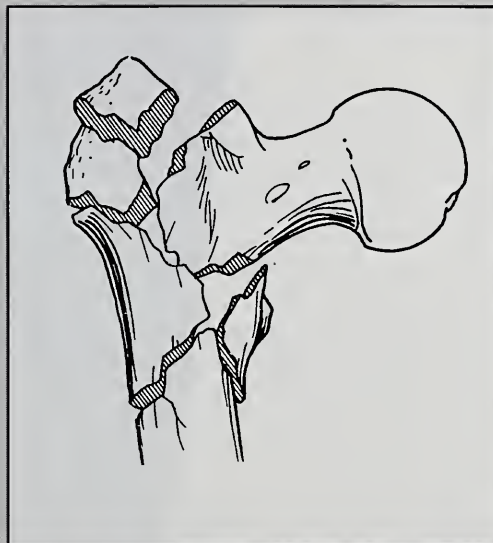
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ILLUSTRATION BY JOHN BERRY

FAMILY TIES

Strong links to the past have created a promising future for family physicians—the front-line docs who care for our communities.

BARBARA P. YAWN, M.D.

As historians Will and Ariel Durant remind us, “The future never just happened. It was created.” And Minnesota’s 2,500 family physicians are considering their 50 years of history as they look to the future and the opportunities that lie ahead.

What created the future for family physicians? A history of hard work, skill, professional growth, and the advocacy of a specialty association. Family medicine has moved from a profession of general practitioners and local medical doctors to one of premier clinicians, many of whom work for managed care organizations. States like California are even encouraging their overabundant subspecialists to retrain in family practice.

In the past 25 years, we have evolved from a group that included few residency-trained physicians to a specialty that requires residency training for board certification and even offers fellowships in areas such as geriatrics, research, and sports medicine. Our specialty is called upon to work with other medical professionals to develop practice guidelines, to recommend modifications in national immunization and patient care policies, and to review and critique the academic pursuits of our colleagues in many disciplines.

Family medicine was the first specialty to provide time-limited specialty certification requiring recertification by examination and practice review every seven years. Stringent continuing medical education requirements have assured that members of the state and national academies of family physicians are participants in closely monitored educational activities. At a time when some organizations would like to turn primary care over to allied providers with less extensive training, family physicians have reaffirmed the importance of broad-based and in-depth training for the caregiver who provides the majority of medical services to patients—the primary care clinician.

Years before most medical educators recognized the value of including community rotations in physician training, family medicine residency programs were tackling the difficult task of providing community-based education to thousands of residents, even basing entire education programs in community medical facilities.

For people with limited access to medical care, family physicians have often provided a safety net of community-based care. We must continue to serve as advocates for our individual patients, while supporting access to health care for all people. We have begun to support that role with information from community- and practice-based research that con-

firms our successes and allows us to design solutions for our lapses.

Modern health care is founded on many of the concepts molded by family medicine. Primary care is no longer a specialty for those who could not make it into a specialty or subspecialty fellowship. Fewer medical students will experience the little talk the chief of medicine had with me, when he suggested, “You don’t have to be a family physician; you have real promise.” Rheumatologists, allergists, and surgeons point to the many elements of primary care they include in their practices. In some states, cardiologists and even neurosurgeons are calling themselves primary care providers.

Our 50th anniversary is a time to celebrate the strength, persistence, excellence, and achievements of family physicians, but the future of family medicine lies in our ability to integrate into the family of all physicians. Physicians of all specialties must work to maintain our central role in medical decision-making by reminding patients, politicians, and payers of our excellent record of providing the best medical care available in any nation.

Gag rules, red tape, service denials, and the alphabet soup of insurance and management programs are signs of the power struggles taking place in the health care world. Such struggles often highlight the worst in all participants. Working together, physicians of all specialties and our representatives in St. Paul and Washington, D.C., are making steady progress to curb the most excessive and most ill-conceived attempts to control health care utilization and costs.

Recent federal legislation guaranteeing insurance portability, prohibiting HMO gag rules, establishing minimum maternity stays, and preserving patient choice of physicians signals that family physicians, with the cooperation of all physicians, can continue to improve the future of health care.

Family medicine’s future is being created by talented, dedicated physicians. Over the past 50 years, our predecessors have established time-tested ideals and standards for those who will continue to care for our communities. MM

Barbara Yawn is a family physician and director of clinical research at the Olmsted Medical Center in Rochester, Minnesota. She is a member of the Minnesota Medicine Advisory Committee.

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BACK TO THE FUTURE

Family practice makes a comeback as the Minnesota Academy of Family Physicians turns 50.

BY MIRIAM K. FELDMAN

When Patricia Lindholm, M.D., graduated from George Washington University's medical school in 1983, she was discouraged from doing a residency in family practice. In fact, the specialty was not even discussed as an option, so Lindholm came home to the Midwest, which was, and still is, considered a bastion of family practice, to train at St. Luke's Hospital in Milwaukee. "I think more of my graduating class would have gone into family practice if they'd had the least

encouragement," says Lindholm, who practices with the Fergus Falls Medical Group and is board chair of the Minnesota Academy of Family Physicians (MAFP), which celebrates its 50th anniversary this year.

Encouragement, however, was in short supply in 1983. Family practice, established in 1969, was still a young specialty. "[Family practice] certainly did not have the degree of prestige and the presence in a lot of academic medical centers as it does now," says Lindholm. ➡



COURTESY OF THE NORMAN ROCKWELL MUSEUM AT STOCKBRIDGE. © CURTIS PUBLISHING COMPANY



DR. ALFRED M. RIDGEWAY LEAVING ON A HOUSECALL. ANNANDALE, 1945. MN HISTORICAL SOCIETY.

"We've taken the best of the old-time family doctor but added the specialty training."

—ROBIN HAYNES

"Family practice is the most challenging specialty of all."

—PATRICIA LINDHOLM, M.D.



DR. J.W. CRUMP, 1938. MN HISTORICAL SOCIETY.

As the direct descendant of general practice, where little if any training was required beyond four years of medical school, family practice for many years seemed out of step with a medical world in which narrow specialization and high technology had become synonymous with progress. As MAFP's executive vice president Virginia Barzan explains, "In this day and age, it's a modern thing to be more focused in a particular area. There's [an assumption], even among the public, that if you're not focused in a particular area, you may not know enough."

In fact, family physicians, who complete a three-year residency covering six broad areas of medicine—pediatrics, internal medicine, obstetrics and gynecology, surgery, psychiatry, and community medicine—say they know enough to handle 80 percent to 90 percent of presenting conditions. Yet it's common, even inside of medicine, to speak in terms of primary care physi-

THE CREATION OF A NEW ORDER

Family practice has been around practically forever, when you consider its historical antecedent—general practice. It is also one of the newer specialties, having established itself relatively late in the game, in 1969, as a board-certifiable specialty requiring three years of training beyond medical school.

Before there were family physicians, there were general physicians who, after four years of medical school and perhaps a little extra training, hung up a “physician and surgeon” shingle and went to work. “In the ’50s, unless you chose to specialize, you took a year’s rotating internship and then hung out a shingle. That’s exactly what I did,” says

O. Guy Johnson, M.D., who practices with Minn-Health Family Physicians, a multisite family practice group in St. Paul. “You just opened an office and said, ‘Here I am.’ That’s what virtually everyone did.”

World War II changed all that, according to Robert Quello, M.D., who retired in 1984 after 47 years in practice. Returning veterans took advantage of the GI Bill to study specialized medicine at government expense. As a result, more physicians moved from rural to urban areas, where the population was large enough to support specialty practice. At the same time, it became more difficult for general practitioners to get hospital admitting privileges, recalls Quello, who had staff privileges at the old Swedish Hospital and offices at 41st and Chicago Avenue and in the old Marquette Bank building, the site now occupied by the IDS building.



DR. ROBERT QUELLO, 1991.

With all those changes going on, a number of general practice physicians saw the writing on the wall and in 1946 founded the Minnesota Academy of General Practice (MAGP). In a sense, it was a move for survival. When Quello started practicing in 1936 after graduating from the University of Minnesota, GPs still accounted for 80 percent of all doctors. By 1945, 33 percent of medical students planned to enter general practice, down from 55 percent in 1940.

MAGP was established as a positive front for those doctors who called themselves physicians and surgeons. It was founded “to develop an organization that would focus primarily on continued training, like others were having continued training in their [specialty],” says Quello, who was an early MAGP member.

By 1969, the training became as formalized as that of other specialties, with the establishment of a three-year residency program. Three years later, following the lead of the national organization, the MAGP became the Minnesota Academy of Family Physicians (MAFP), which is now 2,500 members strong and celebrating its 50th anniversary.

Johnson, who was MAFP president in 1980, credits the leadership of a strong base of pre- and postwar GPs with keeping general practice alive. “[They] were here to help make the transition to the new order, which was the creation of the specialty.”

—MKF



DR. ALFRED M. RIDGEWAY, 1945. MN HISTORICAL SOCIETY.



ADMINISTERING A BLOOD PRESSURE TEST, ca. 1940. MN HISTORICAL SOCIETY.



DOCTOR'S OFFICE, ca. 1908. PHOTO BY THE FLASH-LIGHTERS. MN HISTORICAL SOCIETY.



DR. BLACK, FAIRFAX (?), MINNESOTA, 1907. MN HISTORICAL SOCIETY.

cians and specialists, as if somehow specialists, or “limited specialists,” as family physicians call them, are more special than primary care doctors, Barzan says.

But the tide is turning. Family practice, which touts a high-touch style in this high-tech world, has made a comeback, due in part to economic factors as well as to a growing public demand for more personalized care. “We like to think that we’ve taken the best of the old-time family doctor but added the specialty training,” says Robin Haynes, MAFP’s associate director.

As O. Guy Johnson, M.D., sees it, family medicine, once near demise, is experiencing a kind of renaissance. “Family medicine has achieved a level of recognition and acceptance that we don’t need to apologize for,” says Johnson, who practices with MinnHealth Family Physicians, a multisite family practice group of 40 physicians in St. Paul. Johnson, who was MAFP president in 1980, talks of family practice as if it were an endangered species that is now reclaiming its rightful position in the scheme of things. “We will always need a certain percentage of generalist physicians, and we’ll need plenty of consultants. We were in danger of losing the one at the expense of the other.”

Much of the shift has to do with the big changes going on within the medical marketplace: family physicians are the darlings of managed care. ➡

“An FP has to be
a little less of a
scientist and more
of a humanist.”

—KEN KEPHART, M.D.

HORSE, BUGGY GONE; FAMILY DOCTOR STAYS

By Wendell Weed, *The Minneapolis Star*, May 2, 1951

The horse and buggy doctor is not disappearing from the Minnesota health scene—just his horse and buggy are gone.

Perhaps the liveliest group of doctors attending the 98th annual meeting of the Minnesota State Medical association is the Minnesota chapter of the American Academy of General Practice.

Some are from the metropolitan areas but the majority are from the smaller communities. They are predominantly young men, energetic and almost collegiate. But there is a scattering of men rich in years of experience in general practice and proud to be known as "family doctors."

So great is that pride that you often hear members of this group comment that being a general practitioner demands the highest intelligence and greatest physical energy.

Backing them up in that belief are Dr. J.P. Sanders, Shreveport, La., national president of the academy, and Dr. Walter C. Alvarez, Chicago, former head of the medicine division of Mayo clinic and now editor of the academy's monthly journal, "GP."

The academy is only four years old, born June 10, 1947, at Atlantic City, N.J., with 108 members.

Since then it has grown to become one of the largest medical organizations in the world with a membership of nearly 15,000 and still growing.

In Minnesota the American Academy of General Practice absorbed the American College of Physicians and Surgeons in 1947 and now has a membership of 299 doctors. There are local chapters in Minneapolis, St. Paul, Willmar, Mankato, Little Falls, St. Cloud, and Hutchinson.

But the figure of 299 is due to be revised upward under an intensive campaign for members being conducted here this week by Dr. Albert E. Ritt, St. Paul, state president, and other officers.

Dr. Sanders and Dr. Alvarez are assisting in the recruiting.

The president was on the first board of directors four years ago and organized the first state chapter in

Louisiana at that time.

Now there are chapters in every state and also the District of Columbia and Hawaii.

Dr. Sanders says every family needs a family doctor and describes that doctor as one who knows when a specialist is needed. He has no quarrel with specialists and declares he wouldn't practice in a town that lacked them.

But he points out that the family doctor himself is a specialist. That is reflected in the academy's requirement that every member must take 150 hours of graduate study every three years in order to remain a member.

"If a specialist is willing to take off three years of his career in order to specialize, then the GP must be willing to spend an equivalent amount of time to keep up," Dr. Sanders explained.

Dr. Alvarez's position with the group is unique. By experience he is a specialist. By inclination and family

background his interest lies with the family doctor.

His father, the late Dr. Luis F. Alvarez, was a family doctor in California and Hawaii. The son, now nearly 67 years old, was in private practice three years.

Dr. Alvarez thinks too many doctors are depending too much on laboratory tests and X-rays to diagnose their patients' ills.

Such things are important, he admits, but he urges doctors to "look the patient in the face, watch him walk and listen to him talk."

"So many of the ills today are due to strain, unhappiness, sorrow and fear," he said in a talk to academy members. "An X-ray won't show that your patient is dying of a broken heart."

One question a doctor should always ask a patient, according to Dr. Alvarez, is: "Are you happy?"

"When you are having trouble in making a diagnosis and all other things have failed to indicate what is wrong, talk with the patient's wife or husband," he advised. "Then you usually will find a clue that will guide you."

Reprinted with permission from the Star Tribune.



DR. LEWIS AT HOME OF MRS. T.T. HICKS. ALEXANDRIA, 1876.
PHOTO BY N.J. TRENNAM. MN HISTORICAL SOCIETY.



HEALTH EXAMINATION AT A PUBLIC SCHOOL, ca. 1940 MN HISTORICAL SOCIETY.

"Family practice is so core that it keeps coming back as the best way to deliver care."

—VIRGINIA BARZAN



CHILDREN'S CLINIC, ca. 1925. MN HIST. SOCIETY.



ROY ANDREWS AND REO AUTOMOBILE IN FRONT OF ANDREWS CLINIC, MANKATO, 1909. MN HISTORICAL SOCIETY.

"We tend to provide cost-effective care and don't tend to use as many resources," Lindholm notes. In fact, family physicians know that at times, the best treatment may be nothing more than time and understanding. Lindholm says she spends a lot of time simply listening to patients. "They just need a person to talk to, somebody to care. Many times, that's more important than the prescriptions, the tests that we order."

As MAFP's president, Ken Kephart, M.D., puts it: "Communication is one of the key things we think we do very well."

Johnson, however, challenges the widely held belief that managed care is responsible for the in-

creased demand for family physicians. "It's a chicken and egg thing," he says, suggesting that managed care grew as a result of family physicians. "I suspect it may be as much that as the other."

Whatever the reason, more students are being drawn to the specialty. They're different, too, according to Kephart, who is administrator of the University of Minnesota's residency program for family practice at Methodist Hospital. Whether students are merely sensitive to shifting economic winds, or whether they truly are, as Kephart puts it, a different breed than he saw 10 years ago—more altruistic and more interested in serving the underprivileged—the number and quality of applicants to his program have gone up. "[Family practice] is viewed as a more valued specialty than it was 10 years ago," he says.

Nationally, the numbers are up, as well. According to the April 1996 *FP Report*, a publication of the American Academy of Family Physicians, the number of medical students interested in family practice continued its upward climb for the fifth consecutive year. This year, the number of family practice residency positions reached an all-time high of 1,840, exceeding last year's match by 277—a far cry from the three students who graduated in 1969, the year the residency was established. In addition, the number of women and people of color entering the profession has increased dramatically. Between 1984 and 1994, the number of women in U.S. family practice residency training programs doubled, while the number of minority group members training in family practice grew by almost 300 percent.

Lindholm, who completed her residency 10 years ago, says she'd go into family practice all over again. "I think family practice is the most challenging specialty of all, because you have to have a broad range of responsibility and a broad range of knowledge. That's why physicians shied away from it. [Many] felt it was more comfortable to master a small amount of material and feel good in your expertise."

Small, however, is not beautiful in family medicine, where the big-picture is key. Family medicine emphasizes cradle-to-grave care. The whole-person philosophy is a cornerstone of the specialty: family physicians believe it's important to know something of a patient's life history. "It appeals to me to take care of families," Lindholm says. "To see people and know who their grandmother is, their aunt, their sisters and brothers."

For Lindholm, the long-term relationship is what counts, because it allows her to see the presenting condition in the context of the patient's life. "There's something more valuable to that than treating someone for bronchitis," she explains. Knowing the context helps the physician understand why a patient presents with a certain condition, and may even explain why some patients visit a doctor in the first place. "Some people have a cough or cold and they

don't think of coming to a doctor for it. They know it's self-limited and treat it at home," Lindholm says. "You can take another person with the same symptoms ... maybe there are family stresses, family violence, depression, or anxiety, and these symptoms take on new meaning. They become more ominous, [so the patient] worries about cancer or pneumonia."

Like Lindholm, Richard Schindler, M.D., who practices in the rural farming community of Adams, Minnesota, population 800, relishes the breadth of family practice.

Variety is the spice of his life. In a typical week, Schindler might be on hand at a girls' basketball game in neighboring Austin in case there are injuries. (He and other area family physicians volunteer regularly at all local youth sports events.) That same week, he might visit the local nursing home and also appear at a couple court guardianship hearings on vulnerable adults who are no longer able to care for themselves. All this is in addition to his work as director of medical education at the Austin Medical Center/St. Olaf Hospital (a volunteer job he's held for the past 20 years) and his normal schedule tending to patients at the Austin Medical Clinic. Schindler also makes house calls for shut-ins.

The variety "makes life fun," he says, though he concedes others might find it onerous. "I really couldn't ever focus down to one age or disease that I was interested in," says Schindler, who received the MAFP's 1993 Minnesota Family Physician of the Year Award. Family practice is probably not a good choice for somebody interested solely in doing research or working only with Parkinson patients, he says.

Kephart agrees. "You have to be a little less of a scientist and more of a humanist, because the basic work is being able to assimilate all the new information and technology and being able to communicate with the individual so they can understand it." That, he says, requires different skills from basic science researchers.

Schindler has been compared to Norman Rockwell's country doctor, but just below that down-home surface ticks a highly trained physician who did a three-year internship in internal medicine, obstetrics, and pediatrics, and who is certified in both family practice and gerontology. Schindler practices "high-touch" medicine with the knowledge and confidence of someone trained in the modern, high-tech world.

The modern world, in fact, came a little closer to the tiny town of Adams two years ago, when the Mayo Clinic took over the Adams Area Medical Clinic, a regional office of the Austin Medical Center. Together, they're known as a Mayo Health Systems Clinic. That makes Schindler an employee. While the new arrangement hasn't affected Schindler's practice style, the mushrooming paperwork that goes hand in

hand with managed care (something not exclusive to family practice) is a frustration, he says.

On the other hand, Schindler acknowledges that managed care's emphasis on primary care physicians working the front lines ties in nicely with the family practice philosophy of developing long-term relationships with patients. "Mayo Clinic has taken us over with the idea that we would be the gatekeepers ... to keep the patients from wandering here, there, and everywhere."

Kephart agrees that the gatekeeping function makes sense, though he prefers the term "care coordinator," because gatekeeping implies that patients are denied entry to the system. Kephart views family physicians as medicine's quarterbacks. Their job is to look at the person as a whole and to make sure care is coordinated in a way that achieves the best outcome.

Critics, however, argue that denying access to specialists is the intention of managed care and fear that, as a result, patients don't always get optimal care. Medicine has become so exacting, they contend, that even treating a simple allergy requires highly specialized knowledge. Kephart counters that most family physicians don't practice in isolation and are in contact with other consultants. At Park Nicollet Clinic, for example, specialists regularly lecture primary care physicians to inform them about new advances and medications.

"Unmanaged care" had its own set of problems, says Kephart, because patients got used to choosing whatever specialist they believed was best to address their problem, and all too often, expensive tests were ordered for a self-misdiagnosed condition. "It's not that we want to take over and control and take care of all the patient's problems," he says. "Basically, [gatekeeping] targets resources to where they're used best." When done well, it can improve patient care. "Unfortunately, that isn't always the case. Managed care is a huge, almost nondefinable term. Some plans do a very good job, and others don't."

To that end, understanding and working with managed care has become a top agenda item for the MAFP, which is the largest specialty society in the state, representing more than 2,500 family physicians, family practice residents, and medical students. One concern, according to Kephart, is finding a way to

maintain a healthy physician-patient relationship within the confines of managed care's rules.

"With all the changes in health care, our physicians are feeling a real need to get their professional organization to speak in a stronger voice to the different health plans on this issue," Kephart says. "We were affected severely in the early stages of managed care, when employers were shopping for health plans like life insurance and switching every year or two." That, of course, was a direct assault on the specialty's cradle-to-grave, whole-family approach. But Kephart says that era is almost over in the Twin Cities. Health plans and employers are recognizing the cost of constant switching. "We're over the hump on that."

As the MAFP celebrates its golden anniversary, it can look back and say it's over many humps, the biggest being the near demise of family medicine. Barzan, however, argues that general medicine was actually never close to extinction, and that it will be around forever. "It is so core that it keeps coming back as the best way to deliver care," she says. "Many times we use the words 'back to the future.' That's what I sense family practice is looking at. We knew all along what was best, and the future is catching up to those past, core values."

MM

Miriam Feldman is a Minneapolis free-lance writer and a frequent contributor to Minnesota Medicine.



DR. ALFRED M. RIDGEWAY MAKING A HOUSECALL, 1945. MN HISTORICAL SOCIETY.

MMA Annual Meeting

Schedule of Events

Wednesday, Sept. 18

10 a.m. to 6 p.m.
General registration

10 a.m. to 12 noon.
MEDPAC Annual Meeting

12:30 p.m. to 3:30 p.m.
Board of Trustees
lunch meeting

4 p.m. to 6 p.m.
1996 Issues forum

6 p.m. to 8:30 p.m.
Welcome reception
(buffet, hospitality)

MMA Annual Meeting
September 18-20, 1996
Northland Inn
Brooklyn Park, Minnesota

Thursday, Sept. 19

6:45 a.m. to 5 p.m.
General registration

7 a.m. to 8 a.m.
Medical Student Section

7:15 a.m. to 9:15 a.m.
Component society caucuses:
• Ramsey • Hennepin
• Greater Minnesota

8:30 a.m. to 9:15 a.m.
Media briefing

9:30 a.m. to 10:45 a.m.
House of Delegates (Session I)

11 a.m. to 12 noon
AMA open forum

12 noon to 1:30 p.m.
Awards lunch

1:30 p.m. to 4:15 p.m.
Reference Committee open hearings

4 p.m. to 5 p.m.
Resident Physician Section

4:15 p.m. to completion
Reference Committee exec. session

4:30 p.m. to 5:30 p.m.
AMA delegation meeting

4:30 p.m. to 6 p.m.
Organized Medical Staff Section
Young Physicians Section
Women Physicians

6 p.m. to 6:30 p.m.
Pre-inaugural reception

6:30 p.m. to 8 p.m.
President's inaugural dinner

8:15 p.m.
"Ring of Fire," a play by Syl Jones

9:30 p.m.
Afterglow reception

Friday, Sept. 20

7 a.m. to 8 a.m.
Board of Trustees
breakfast meeting

8 a.m. to 12 noon
General registration

8 a.m. to 10 a.m.
Minnesota Society of
Pathologists Exec. Committee

8 a.m. to 10 a.m.
Component society caucuses:
• Ramsey and Hennepin
• Greater Minnesota

10:15 a.m. to 3:30 p.m.
House of Delegates (Session II),
includes lunch

12 noon
Spouse luncheon

3:30 p.m.
Board of Trustees
organizational meeting

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Gatekeeper Liability and Managed Care

Primary care physicians acting as gatekeepers may face new liability risks but can take steps to prevent lawsuits.

James B. Platt, J.D.

Primary care doctors play a big role as coordinators of care, or "gatekeepers," in many managed care plans. Patients are required to see their primary care doctor first, and the doctor—the gatekeeper—determines if referral is needed. Managed care contracts often include financial incentives to encourage gatekeepers to control costs. In addition to such traditional managed care activities as performing precertification approval and concurrent review, plans are working with gatekeepers to determine optimal primary care staffing levels and develop quality indicators. Gatekeepers are also working with nurse practitioners and physician assistants, as well as establishing telephone triage lines, to manage growing populations of plan enrollees.

The unique position gatekeepers hold in managing the care of their patients may raise new liability issues. In the past, primary care physicians have had one duty—to provide quality care for their patients. Now, as gatekeepers, they are being asked to watch health care costs, as well. Many patients have a hard time understanding why they cannot receive the benefits to which they feel entitled. More than ever, the focus is on gatekeepers to make the right decisions. This article addresses how gatekeepers can minimize liability risks as they balance these objectives.

LIABILITY CONCERNS

Few court decisions have involved gatekeeper liability under managed

care. As in many areas, the law lags behind changes going on in the market. But this may change in the future. Managed care is growing rapidly across the country, and court decisions in other states may affect future cases in Minnesota. Some of the hot liability areas elsewhere include inappropriate economic incentives, responses to utilization review measures, negligent referral or non-referral, supervision of physician assistants and nurse practitioners, and direct contracting.

INAPPROPRIATE ECONOMIC INCENTIVES

The 1993 decision in *Fox v. HealthNet of California* points out the dangers of creating the appearance that financial decisions dictate patient care. In this case, HealthNet, a for-profit HMO, was sued for refusing to pay for an autologous bone marrow transplant for an enrollee who subsequently died from breast cancer. Although HealthNet's policy listed bone marrow transplants as covered services, treatment was denied on the grounds that the procedure was experimental when attempted at later stages of breast cancer.

The estate, represented by the deceased enrollee's brother, showed that a HealthNet internal study had found that treatment prevailed at three of four other HMOs, and that in this case, the procedure was denied only after a HealthNet executive changed his recommendation. Perhaps most damaging, however,

was the plaintiff's argument to the jury that the executive received bonuses based on the denial of costly medical procedures. Although the case was later settled on appeal for an undisclosed amount, the jury ordered HealthNet to pay almost \$90 million in damages to the estate, including \$77 million in punitive damages.

A number of other cases have been filed against physicians and HMOs alleging that improper financial incentives led to negligent care. In a recent Texas case, state investigators found that four psychiatric service companies were compensated based on the number of individuals admitted for inpatient treatment. The companies agreed to pay \$480,000 to settle allegations that they illegally treated patients as "commodities."¹

State legislatures have also become involved. In Maine, for example, lawmakers have passed bills that require plans to disclose their financial arrangements with providers. Similar disclosure rules have been proposed for certain Medicare and Medicaid contracts.

These cases point out the importance of making sure financial incentives are appropriate. Incentives tied to quality indicators or broadly based cost targets are safer than those that tie dollars to particular procedures.

RESPONSES TO UTILIZATION REVIEW MEASURES

Managed care plans frequently use utilization review and case manage-

ment to control costs. Although most managed care plans have well-established review and appeal mechanisms, conflicts can still arise between what gatekeepers believe is appropriate care and what the plan is willing to pay for. The courts have not clarified how far physicians must go on their patient's behalf to respond to these conflicts. The most important case to date is still the mid-1980s California decision of *Wickline v. State*.²

In that case, Medi-Cal, California's Medicaid program, refused to grant a request for additional hospital days for Lois Wickline, who experienced complications following surgery to treat circulatory problems in her leg. Her treating physician requested an eight-day extension to her scheduled discharge date. However, Medi-Cal approved an extension of only four days. Wickline was discharged after the four-day extension but had to be readmitted nine days later. Eventually, her leg was amputated. She brought suit against Medi-Cal, alleging that the payer had been negligent in failing to approve the full eight-day extension.

The California court ultimately held that Medi-Cal could not be held liable for negligence in this case because the actual decision was made by Wickline's physician, not the payer. Although Wickline did not sue her physician, the court was greatly disturbed by the physician's conduct. The court noted that physicians have a responsibility to inform patients when they disagree with decisions regarding coverage, and in refusing to find Medi-Cal liable, the court implicitly criticized the physician for failing to challenge the health plan's decision.

One reason for the small number of cases in this area is that courts have been reluctant to find managed care companies liable for malpractice. The courts have ruled that state law claims like malpractice are precluded under federal employee benefits laws. Without a utilization reviewer to blame, however, patients may increasingly turn against physicians and hospitals for recovery. So there may be more cases like Wickline in the future. And, recent court cases are forging new ways to hold

plans responsible for the actions of plan physicians. As a result, some plans may let physicians make more decisions regarding patient care, so long as they are financially accountable for the result.

NEGLIGENT REFERRAL OR NONREFERRAL

Gatekeepers must be particularly careful with referrals. They need to have confidence in the specialists available before agreeing to participate in the plan. Communication between the specialist and the gatekeeper is also very important. Who will tell the patient about test results? Schedule the follow-up? Determine if more tests are necessary? The presence of economic disincentives for referral may also magnify the risk of liability. Although Minnesota courts are careful regarding the admission of such inflammatory evidence, plaintiff attorneys elsewhere have had success introducing evidence of financial incentives and creating the suggestion that finances played a role in physicians' decisions regarding referrals.

SUPERVISION OF PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

Many gatekeepers have found that physician assistants and nurse practitioners can play an important role in providing patient care. But, as practices take on more patients, gatekeepers need to be careful that all providers practice within the realm of their expertise. This is an area of potential liability³ (see related article, page 29). Telephone triage lines are also becoming more common, and gatekeepers need to consider how and when physicians should respond to the calls and how to document any medical advice given.

DIRECT CONTRACTING

Gatekeepers who directly contract with self-insured employers face other liability issues when they perform both provider and payer functions. Clinics that handle their own credentialing and hiring of specialists will likely face the same kinds of claims that managed care plans have in the past. Managed care plans have also

been keenly aware of the potential liability involving their appeal and utilization review programs. Clinics that take over some of these functions will need to structure their programs in accordance with industry standards.

RISK MANAGEMENT

To minimize the risk of liability arising because of improper economic incentives, responses to utilization review, or negligent referral, gatekeepers should do the following:

- **Continue providing good medical care.** Undoubtedly, the best way to minimize liability is to continue practicing good medicine. Gatekeepers should not permit their treatment decisions to be based on financial incentives. Fortunately, few Minnesota cases have dealt with managed care liability. Nonetheless, gatekeepers should not let their guard down. Cases in other states may become influential in Minnesota.

- **Fully explain risks and alternatives.** Gatekeepers should explain fully to patients the recommended course of treatment. If, for example, a patient's managed care plan will not pay for additional hospital days, and the physician believes the early discharge creates a risk, the physician should explain that to the patient.

- **Document recommendations and decisions.** Gatekeepers should objectively document in the patient's medical record the course of treatment recommended and the patient's decision. In doing so, physicians should be careful about how they express frustrations with the managed care plan. In one California case, the jury reportedly would have found the physician negligent (had he been a defendant) partly because the physician noted in the medical record that the patient had to be discharged "because of pressure" from the utilization review company.⁴

- **Go to bat for the patient.** Gatekeepers may need to act on behalf of the patient by questioning the managed care plan's decisions. The *Wickline* decision suggests that if a treating physician disagrees with the treatment plan, he or she should investigate. Was the person who made

the benefit decision a physician? If so, was the physician trained in the specialty? Is the patient aware of his or her right to appeal? It is unclear how far doctors must go to satisfy their duty of care. Some commentators have suggested that physicians may need to help patients take advantage of any rights to appeal an HMO's decision, particularly if the patient is physically or mentally unable to do so or does not have the necessary resources or information to do so.

- **Be leery of advertising or guaranteeing the "best care."** Gatekeepers should be careful in designing their ad campaigns and should be particularly leery of advertisements that present them as the "highest quality" providers. Medical groups that promise the best care in their managed care contracts may be holding themselves to a higher standard. Although it is difficult for patients to sue for "breach of warranty," the gatekeeper may be asked to indemnify the plan if it has to settle a case because of the gatekeeper's poor care.

- **Beware of overly broad indemnification clauses.** Contract language that keeps gatekeepers on the hook for results that "arise out of" the gatekeeper's conduct are far too broad. Many times these clauses could be used to force the gatekeeper to reimburse a plan for its losses, even though the gatekeeper was never proven negligent. And most malpractice insurance companies will not cover those costs unless they agreed to do so ahead of time. Other indemnification clauses require that the gatekeeper pay the plan's settlement costs, including its attorney fees. These clauses should be avoided. If they cannot be avoided, physicians should be sure the clauses use language that makes the physicians liable for their *own* negligence. Because these clauses are often complex and contain legal jargon, legal counsel should review managed care contracts before they are signed.

- **Closely supervise triage lines.** Gatekeepers obviously need to work closely with other health care professionals on their staffs. Groups that use telephone triage lines should have

protocols dealing with such issues as when and how soon a physician will call the patient back and the documentation of any advice given.

Although Minnesota has had few cases involving managed care or gatekeeper liability, there are no hard data to explain why. Many people believe that Minnesota has found the right balance between providing good patient care and controlling costs. While this may be true, gatekeepers who keep an eye on emerging court trends and use risk management ideas to lessen liability will have an added layer of protection. MM

James Platt is a shareholder and officer of Fredrikson & Byron, P.A., in

Minneapolis, and co-chair of its Health Law Practice Group.

REFERENCES

1. Texas settles psychiatric patient recruitment suits. BNA Health Law Reporter 1994;3:1789.
2. Wickline v. State, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810 (1986), cert. granted 727 P.2d 53, 231 Cal. Rptr. 560 (1986). rev., dismissed and remanded, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).
3. Note, Vicarious Liability of a Physician for the Negligence of other Medical Professionals, 17 Campb. L. Rev. 321 (1995).
4. Azevedo D. Courts let UR firms off the hook—and leave doctors on. Med Econ 1993;70(2):30-44.

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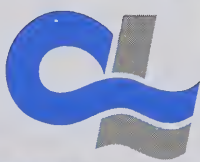
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Liability and Allied Health Professionals

Whose Risk Is It Anyway?

*Employing allied health professionals can improve patient care,
but physicians should be aware of the liability risks
and close any malpractice gaps.*

Midwest Medical Insurance Company, Risk Management Committee

Physicians frequently employ allied health professionals (AHPs) at some level within the clinic or office setting and should be aware of the responsibilities and risks that go hand in hand with that employment. Understanding your duties when working with AHPs can help you identify gaps in your practice that may expose you to a medical malpractice claim if your AHP is negligent.

VICARIOUS AND DIRECT LIABILITY

A medical malpractice claim arises from professional negligence or a failure to meet the applicable standard of care in treating a patient. When a physician is held liable for his or her own negligence, the connection is clear: If you breach a standard of care and your patient is injured, you may be liable for damages to that patient.

But what if an AHP breaches a standard of care and injures your patient? Depending upon your relationship to the AHP, you may be held "vicariously" responsible. In medical malpractice law, as in many other areas, employers and supervisors are generally responsible for the negligence of employees operating within the scope of their employment. Thus, if you employ or supervise a nurse practitioner, a physician assistant, or a physical therapist and that employee injures a patient, you may be held liable. The law imposes upon

you ultimate responsibility for medical care and treatment rendered to your patients.

A common situation might involve an AHP who performs delegated medical duties, such as physical examinations, within a clinic. The AHP uses written protocols and is subject to direct physician supervision. If, for example, the AHP commits a diagnostic error that results in a patient injury, the physician may be held vicariously responsible for the misdiagnosis.

In a case like this, the physician may also have direct liability exposure related to the AHP's acts. What is the physician's mistake? Usually, it is the failure to appropriately supervise or monitor the care rendered by the AHP. In many situations, the supervising physician could have or should have caught the error, thus preventing the patient's injury. The physician's duty to supervise may require working as a collaborative team, minimizing the risks to patients by remaining involved in their care. Making your office or clinic function more as a health care team can improve the continuity of care provided to all your patients.

AHPs can be held directly liable for their own negligence, but their individual liability is rarely pursued. Generally, the claim is brought against the clinic and any involved physician.

AHP LIABILITY RISK AREAS

As part of the clinical care team,

AHPs are beneficial to physician practices, and their benefits frequently outweigh any increased liability risks. But physicians should recognize and consider the risk areas when hiring an AHP. If you employ AHPs, evaluate your own practice to determine whether the arrangement exposes you to increased malpractice risk. Consider these questions:

- Do you know the scope of practice for your AHPs? If an AHP is providing care outside the scope of his or her license or certification, you may be facing a malpractice risk. Be aware of the licensing requirements for each AHP you employ and establish written guidelines or protocols to ensure their practices are always within that scope.

- Are your AHPs properly identified to patients, or can they be mistaken for physicians? A patient who believes he is being treated by a physician may become angry if there is an adverse outcome and the patient feels deceived. This patient may be more likely to sue than a patient who understood the AHP's role on the health care team. Ensure that all AHPs within your practice are clearly identified as physician assistants, registered nurses, nurse practitioners, etc. All AHPs should immediately and tactfully correct any patient mistakenly calling them "Doctor."

- Is there a process for ongoing review of your AHP's care beyond discussing questions that come up? A system for reviewing the quality and scope of the AHP's patient care must

be in place. Chart reviews, frequent case discussions, and open communications all contribute to the growth and development of the team relationship. A good supervisory relationship will satisfy the AHP's licensing requirements, help prevent mistakes that lead to patient injuries, and close a potential malpractice gap in your practice.

RECOGNIZING THE RISKS

Identifying potential liability exposures is the first step to managing liability risks. The following case examples are taken from closed malpractice claim files and illustrate the points discussed. Can you recognize the risks in these examples?

CASE 1

A 50-year-old man presented with complaints of rectal bleeding. A physician assistant (PA) examined the patient and diagnosed hemorrhoids but did not advise any follow-up. When the patient returned with the same complaints, the PA made the same diagnosis; no physician referral was ever made. Within a few months, the patient was hospitalized, and a large rectal tumor was found.

Liability issue: The clinic had a colorectal protocol, and the patient's continuing complaints should have resulted in a physician's consultation. The protocol, however, was unclear on certain complaints, like hemorrhoid symptoms. The supervising physician was not aware of the repeated visits, although the protocol called for physician supervision. The clinic and the PA's supervising physician were sued.

Risk management tip: Written protocols must be clear, and every practicing health professional in the clinic should be familiar with each one. The protocols should include written guidelines for examination, treatment, delegation, supervision, and physician access. A physician should always see a patient after a predetermined number of visits, for medical as well as patient relations reasons.

CASE 2

A new nurse in an otolaryngologist's office gave a patient an ear irrigation.

The patient complained of sharp pain and sudden dizziness, which the nurse assured him were "normal" reactions to the irrigation. The nurse left the room so the patient could get dressed; the patient fell, striking his head on the exam room sink.

Liability issue: The clinic had not taught the nurse correct ear irrigation procedures. She had previously been employed in an otolaryngologist's office, and the staff assumed she was familiar with proper techniques commonly employed in such a setting. There had been no documentation of her orientation, training, or skills assessment when she was hired, compromising defense of the claim.

Risk management tip: Before hiring an AHP, physicians should check credentials and do a skills inventory. Document the orientation, training, and skills assessment to ensure that all staff are aware of the AHP's abilities or limitations.

CASE 3

A new mother called the clinic and said her 3-week-old child had a runny nose and fever. The office nurse handling the call advised Tylenol and a cool mist vaporizer. The mother called again the following day and reported the child was lethargic. Another office nurse told her lethargy could be a reaction to the Tylenol but suggested the mother might want to bring the child in. Neither call was documented. Sensing no urgency, the mother waited until the following day, when she presented the child, already moribund with pertussis.

Liability issue: The nurses in this case were not qualified to diagnose an infant illness and had inadequate guidelines for handling such telephone calls. The lack of any clinic documentation devastated the defense of the claim.

Risk management tip: Use only appropriately trained, qualified staff for telephone triage. Ensure that personnel triaging calls use written protocols or guidelines and document any symptom-related or treatment advice given to a patient by telephone.

Employing AHPs has many benefits. The above case examples point

out some of the risks that may arise when proper supervision is not provided. From a liability standpoint, there are undoubtedly situations where an appropriately trained and skilled AHP has prevented a patient injury. But, like the healthy patient who is never the subject of grand rounds, malpractice insurers cannot recount those positive case examples because they never become "cases."

LIABILITY INSURANCE COVERAGE ISSUES

Generally, when a physician or a clinic employs an AHP, the professional liability insurance policy covering the physician or clinic covers the AHP as long as the AHP's acts are within the time, place, and scope of the employment. Whenever you employ an AHP, notify your malpractice carrier. Your insurer will want to know what the AHP's credentials and duties are, and you will want to ensure that you are appropriately covered.

When an AHP is an independent contractor, the law does not automatically hold the physician harmless. Rather, the nature of the relationship and the physician's right to direct and control the AHP is examined. If an AHP works with you as an independent contractor, find out what malpractice coverage the AHP has and notify your own carrier of the relationship.

LIABILITY FOR REFERRALS TO AHPs

Physicians making referrals to AHPs, such as athletic trainers, physical therapists, or psychologists, often inquire about their liability for such referrals. The liability issue is whether the referral is negligently made. Physicians are advised to use the same good medical judgment and common sense as in making any other referral. It is always good practice to know the person to whom you refer your patients and assure that you can trust that person's skills and training. AHPs working independently may be required by law to carry their own malpractice coverage; you may wish to inquire about the AHP's coverage

when you ask about credentials.

CONCLUSION

Using AHPs in your practice can be a rewarding, beneficial experience. Recognizing potential pitfalls and closing any malpractice gaps can reduce your risks while improving patient care, patient health outcomes, and the overall satisfaction of the entire health care team. **MM**

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Kenneth W. Crabb, M.D.

Theodore L. Fritsche, M.D.*

Frank J. Indihar, M.D.*

*Current officers and delegation members eligible for reelection

Nominations will remain open through the first session of the MMA House of Delegates at the MMA Annual Meeting.

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MMA/MSBA MEETING DATE IS CHANGED

The Minnesota Medical Association/Minnesota State Bar Association breakfast meeting originally scheduled for September 10 will be held October 15 from 7 a.m. to 9 a.m. at the Sheraton Inn Midway in St. Paul. The topic will be telemedicine. Among the speakers are Thomas Greeson, J.D., of the American College of Radiology and Leo Whelan, J.D., of the legal Department of the Mayo Clinic in Rochester. Watch your mail for a brochure. For more information, call Vicki Westling at the MMA, 612/378-1875 or 800/999-1875.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Will Tackle Tough Issues at Annual Meeting

The MMA House of Delegates will make important decisions about the future direction of the association when it meets this month in Brooklyn Park. More than 40 resolutions have been introduced, raising questions such as: What funding source should replace the 2 percent tax? How should the MMA address problems with the pass-through of the 2 percent tax? Should retired physicians be eligible for MMA office? Should state medical license requirements be standardized? How can we define the appropriate responsibilities of health care professionals? (See pages 37 to 40 for a summary of the resolutions that were submitted by the time *The Monitor* went to press.)

Delegates Will Consider Telemedicine Report

In addition, the MMA House of Delegates (HOD) will consider 47 reports. One report sure to spark debate is the "Report of the Telemedicine Task Force." Last year, the HOD directed the MMA to convene a task force to develop a report on telemedicine and recommend guidelines for the implementation and use of new technologies. This report has been completed and will be presented to the 1996 MMA House of Delegates. It explains the barriers to a more rapid expansion of telemedicine including the controversy over state medical licensure, the lack of credentialing and care standards for telemedicine, possible malpractice complications, the lack of reimburse-

ment for telemedicine, and the possible loss of confidentiality of patients' medical information.

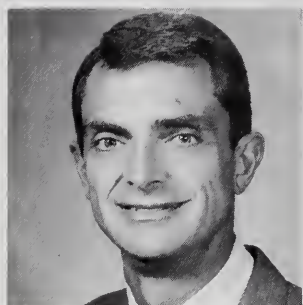
The most controversial question raised by the report is: Should out-of-state physicians delivering care to Minnesota patients via telemedicine on other than an episodic, consultative basis be licensed to practice medicine in Minnesota? The MMA Board of Trustees and the MMA House of Delegates have yet to decide.

The telemedicine report also recommends that the MMA serve as a resource for physicians, policymakers, and others who are interested in staying informed about the development of telemedicine and that the MMA should continue to be an advocate for physicians and patients on issues specific to emerging technologies, including telemedicine and telecommunications. The MMA Board and House of Delegates will decide how active a role the MMA should play in the expanding, but controversial, arena of telemedicine.

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Come to the MMA Annual Meeting

• • • • • ALL MMA MEMBERS ARE invited to attend the 143rd MMA Annual Meeting to be held at the Northland Inn in Brooklyn Park September 18 to 20, 1996. The MMA House of Delegates will be in session on Thursday, September 19, and Friday, September 20.



Viewpoint

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Michael J. Murray, M.D.
President, Minnesota Medical Association

Can We Win Repeal of the 2 Percent Tax?

"We must take the current when it serves, or lose our ventures."

—William Shakespeare

The 2 percent tax has been a thorn in the sides of physicians from the moment it was enacted. From its beginning in 1992, we argued that the MinnesotaCare program for the uninsured should be supported by a broad-based funding source rather than by a tax on health care services.

During the last four legislative sessions, we worked hard to convince lawmakers to eliminate the tax. We initiated proposals to: 1) reduce the 2 percent tax; 2) replace it with an income tax; and 3) reduce the tax and offset it with a tobacco tax. None of these bills received serious consideration.

The familiar refrain at the Capitol has been: "I agree with you, but..." DFL legislators support replacing the 2 percent tax with an income tax, but they're afraid of being labeled "tax and spend" Democrats. They blame the governor for threatening to veto any alternatives. Republicans oppose the 2 percent tax, but they are philosophically opposed to any new taxes to replace it. They blame the mood of the voters.

Despite our past difficulties, 1997 may be the right time to make an all-out effort to break the stalemate and repeal or modify the 2 percent tax.

Why now? The main reason is that the surplus in the health care access fund—even with the recent increase in MinnesotaCare eligibility—is expected to exceed \$338.7 million by FY 1999. Such a large surplus would allow the state to reduce or repeal the 2 percent tax and replace it with a fairly modest alternative tax.

If we don't act quickly, however, the surplus in the health care access fund is likely to be raided for other purposes. MMA policy supports increasing eligibility for the MinnesotaCare program, but this is unlikely to happen in 1997. Last session, the MMA supported a bill that would have raised eligibility for the MinnesotaCare program to 150 percent of the federal poverty level, but the governor vetoed it and instead expanded eligibility to 135 percent of poverty. Lawmakers are unlikely to renew their efforts to expand the program further in 1997.

Since the surplus in the health care access fund is not being used for its intended purpose, lawmakers are devising other uses for the money. For example, Gov. Carlson wants to use the money for medical research and education.

Clearly it's important to fund research and education, but the MMA strongly opposes using money raised by the 2 percent tax for any purpose other than improving access to health care for the uninsured. We may have to fight hard for repeal or reduction of the tax in order to keep the surplus from being siphoned off to fund all sorts of projects.

It may be to our advantage that the political players will change after the November election. The MED-PAC Board is basing its endorsements for the 1996 elections largely on the candidates' position on the 2 percent tax. In addition, we have an opportunity to work in the campaigns of candidates who will support our position on the 2 percent tax.

The MMA is laying the groundwork for a major effort to repeal the tax by testing the level of support from other groups. The HMO Council agrees that a broader-based funding source would be appropriate but is not convinced that it's politically possible to change it. The council will, however, look for ways to make the pass-through work better. Dentists are strongly opposed to the tax. Other provider groups don't like the tax, but they have not actively tried to change it. We are trying to build coalitions.

The MMA Committee on Legislation is developing a detailed action plan to present to the MMA Board of Trustees. A number of options are under consideration. One possibility would be to seek a gradual phaseout of the tax, which would not be as politically difficult as outright repeal.

The question of whether to make an all-out effort to repeal or modify the 2 percent tax will be discussed at the MMA Annual Meeting. The association would have to be committed to this goal and be willing to commit considerable resources, including a personal effort by all MMA members. If we are ever going to succeed, 1997 may offer our best chance.

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ANNOUNCEMENTS

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LINDNER JOINS LOC

Rep. Arlon Lindner, R-Corcoran, has replaced Rep. Roger Cooper, DFL-Bird Island, on the Legislative Commission on Health Care Access. The commission includes five House and five Senate members.

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THE MEDICINE AND PUBLIC HEALTH INITIATIVE

A Public Health Training Network Satellite Videoconference September 30, 1996
12 p.m. to 1 p.m.

Attend the satellite videoconference at one of five Minnesota locations: Hennepin County Medical Center or VA Medical Center in Minneapolis, the Mayo Clinic in Rochester, St. Mary's Hospital in Duluth, or the Minnesota Department of Health in St. Paul.

Speakers include C. Everett Koop, M.D., and the co-chairs of the Medicine/Public Health Initiative, Nancy Dickey, M.D., chair of the AMA Board of Trustees, and Fernando Trevino, M.D., executive director of the American Public Health Association.

The program is sponsored by the Public Health Training Network as a collaboration among the Centers for Disease Control and Prevention, the Public Health Practice Program Office, the American Public Health Association, and the American Medical Association. For more information, call Janet Silversmith at 800/999-1875 or 612/378-1875.

'Ring of Fire' Will Be Performed at MMA Annual Meeting



Mixed Blood Theatre actors Chris Denton and Ninoska Meyer perform "Ring of Fire," a play written by Syl Jones and commissioned by the Allina Foundation as part of its violence prevention activities. The play will be performed at the President's Inaugural Dinner, MMA Annual Meeting, September 19.

MMA Meets With House Minority Leader

On behalf of MEDPAC, MMA leaders and staff met with House Minority Leader Rep. Steve Sviggum, R-Kenyon, and presented him with a MEDPAC contribution to the House Republican Caucus. MEDPAC's contribution recognizes the support of the GOP caucus for the MMA positions on the Vulnerable Adults Act, point-of-service legislation, and the chiropractic truckers' exam bill during the 1996 session. Rep. Sviggum is optimistic that Republicans can achieve a majority in the Minnesota House in 1997.

Looking ahead to the 1997 legislative session, MMA leaders discussed the growing dissatisfaction of MMA members with the 2 percent tax on health care services. Sviggum said he is "totally opposed to raiding the health care access fund for any

purpose other than MinnesotaCare," but he did not promise support for other tax options to replace the 2 percent tax. He did, however, pledge "unconditional support" for the MMA position on the chiropractic truck driver exam legislation, which is expected to be reintroduced in 1997.

Representing the MMA at the meeting were Timothy J. Crimmins, M.D., chair of the MMA Board of Trustees; Raymond Christensen, M.D., MMA president-elect and member of the MEDPAC Board of Directors; A. Stuart Hanson, M.D., MMA past president and member of the MEDPAC Board of Directors; Molly Sigel, associate director of state legislation; Dave Renner, MMA director of policy and legislation; and Paul S. Sanders, MMA CEO.

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MINNESOTA CARE NEWS

SURVEY OF PRACTICE COSTS IS IMPORTANT TO PHYSICIANS

If you receive a survey of your practice expenses, be sure to fill it out. The Health Care Financing Administration sent out a survey of physicians' practice expenses to an initial sample of 1,700 physician practices. Eventually, HCFA will send the survey to 5,000 physician practices and will use the results to develop new resource-based, practice-expense relative values for Medicare's physician payment schedule. At the AMA Annual Meeting in June, the AMA House of Delegates called for a one-year delay in moving to the new Medicare payment system to give HCFA time to complete this national survey and use the data to develop the new values. **It is extremely important that physicians complete the survey so that the new practice-expense values will reflect accurate information from physicians in all areas of the country, types of practice settings, and specialties.** Otherwise HCFA will have to rely on proxies or some type of formula rather than actual practice-expense data.

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X-RAY OPERATOR RULES TAKE EFFECT SOON

On January 1, 1997, legislation will take effect that requires all x-ray equipment operators to pass an examination that has been approved by the commissioner of health or show that they have passed an equivalent national, state, or regional examination that demonstrates basic knowledge of radiation safety, proper use of x-ray equipment, darkroom and film processing, and quality assurance procedures. The law applies to all individuals who operate x-ray equipment. It does not apply to those who only load or unload film cassettes or who only process radiographs after all the

required daily quality control parameters have been met. To obtain information about x-ray operator training opportunities or examination locations, call 612/215-0950.

When this legislation passed in 1995, it was not intended to apply to licensed practitioners such as physicians, dentists, or chiropractors, but the rule does not explicitly exempt licensed practitioners. The Minnesota Medical Association is working with the Minnesota Department of Health (MDH) to make sure that the rule doesn't duplicate existing license requirements.

The MDH published a notice in the *State Register* in July proposing an amendment to the rule that would clarify that people who hold current licenses to practice medicine, dentistry, chiropractic, podiatric medicine, and osteopathic medicine are exempt from this requirement. If the rule cannot be amended, the MDH plans to ask for legislative change in the 1997 legislature.

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PROMPT CLAIMS PAYMENT IS REQUIRED

Effective July 1, 1996, state law requires the Department of Human Services to pay or deny clean claims within 30 days and complex claims within 90 days. "Clean claims" are electronic or paper claims submitted to DHS without any attachments. "Complex claims" are submitted to DHS with attachments, replacement claims, Medicare crossovers, and third-party liability claims. All fee-for-service claims are affected by this law.

If the payment requirements are not met, DHS will pay interest calculated at the rate of 18 percent per year to providers. Claims must be submitted by an enrolled health care program provider for covered services

rendered to an eligible recipient/enrollee of Minnesota health care programs. The 30-day and 90-day requirements are determined by the date the claim enters MMIS II and the date of claim payment. Interest calculations are based on the number of days beyond the initial 30 and 90 days.

For more information, call the Customer Services Provider Help Desk at 612/282-5545 or 800/366-5411.

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GILLETTE CHILDREN'S WILL REMAIN INDEPENDENT

Gillette Children's Hospital unveiled its new name, Gillette Children's Specialty Healthcare, and pledged to remain independent—a rare phenomenon at a time when other hospitals are consolidating, closing, downsizing, or changing. "We seem at times to be a mouse dancing among the feet of elephants," said Al Naylor, vice chair of the board of directors of Gillette Children's Specialty Healthcare, speaking at a news conference in St. Paul August 6. "Yet Gillette has purposefully chosen to remain as an independent entity." Naylor explained that maintaining its independence will allow Gillette to focus on meeting the special needs of children with disabilities. By aligning itself with many systems and providers, Gillette hopes to provide its patients with access to the specialty services they need no matter where they enter into the health care network. At the news conference, speakers U.S. Secretary of Health and Human Services Donna Shalala and U.S. Sen. Paul Wellstone stressed the importance of meeting the needs of children with disabilities.

ANNOUNCEMENTS

**ECONOMIC SUMMIT II:
CHILDREN ARE A PUBLIC
GOOD—INVESTING IN A
HIGH-QUALITY CHILD CARE
SYSTEM**

September 19, 1996
Earle Brown Center—St. Paul
Campus, University of Minnesota
9 a.m. to 5 p.m.

The goals of the conference are to help individuals and groups work toward fully financing the child care system and to define an organizational framework and plan of action. Participants will consider research on an expanded sliding-fee scale and legislative concepts to achieve the long-range goal of a fully funded child care system.

The registration fee is \$25. For more information or to register, call the Alliance of Early Childhood Professionals at 612/721-4246.

**MMA SPONSORS "STOP
THE VIOLENCE DAY AT THE
DOME"**

See the Minnesota Twins take on the Chicago White Sox on "Stop the Violence Day at the Dome," Sunday, September 29. The Minnesota Medical Association is one of the main sponsors of this event, which will focus attention on the problem of violence. A pregame rally beginning at noon in the Plaza will feature music, food vendors, and entertainment as well as displays by violence prevention organizations. The game begins with a major scoreboard welcome at 1:05 p.m. Special half-price lower level seating is available for only \$6.

For more information, call Mark Vukelich at the MMA, 612/378-1875 or 800/999-1875.

MMA House of Delegates will Set Policy at Annual Meeting

The 1996 Minnesota Medical Association House of Delegates will convene in Brooklyn Park Thursday, September 18, and Friday, September 19, to take action on resolutions that will set the MMA's course for the coming year. As *The Monitor* goes to press, the following draft resolutions have been submitted:

Res. 1, Investigation of Birth Defects and Anomalies in Frogs

Introduced by: Kent Wilson, M.D., MMA Trustee

Resolves that the MMA support scientific efforts to investigate the causes of anomalies in the frog population and human birth defects, and work with other organizations and agencies to better understand these anomalies and defects, and to reduce the biologic impact of identifiable etiologic agents.

Res. 2, Edward Purcell Award for Community Service

Introduced by: Kent Wilson, M.D., MMA Trustee

Resolves that the MMA annually award to a young physician in each trustee district the Edward Purcell, M.D., Award for Community Service.

Res. 3, Tobacco Addiction

Introduced by: Zumbro Valley Medical Society (ZVMS)

Resolves that the Minnesota delegation to the American Medical Association call on the AMA to develop legislation that would require tobacco companies to reduce the nicotine content in tobacco products sold in the United States by 20 percent annually until the possibility for nicotine addiction from marketed tobacco is eliminated, and to develop legislation that would require tobacco companies to label their products indicating nicotine content within the smallest consumable unit. In addition, the resolution calls on

the MMA to support similar legislation at the state level.

Res. 4, Continuing Medical Education Mission Statement

Introduced by: Committee on Accreditation and Continuing Medical Education (CME)

Resolves that the MMA adopt the following CME mission statement, as revised by the Committee on Accreditation and Continuing Medical Education and approved by the Board of Trustees: "To accredit, promote, and assist intrastate CME programs, and to provide continuing medical education activities which assist physicians in attaining and maintaining high standards of patient care and professional performance."

Res. 5, Chiropractic Scope of Practice

Introduced by: Lake Superior Medical Society (LSMS)

Resolves that the MMA reaffirm its position that performing a comprehensive physical examination is outside the scope of chiropractic practice in Minnesota, and further resolves that the MMA lobby the legislature to limit the performance of comprehensive physical exams to licensed physicians and ask the AMA to support similar federal legislation.

Res. 6, Exclusive Provider Contracts

Introduced by: LSMS

Resolves that the MMA reaffirm its position prohibiting exclusive contracts and work to extend the current law.

Resolution 7, Role of Advanced Practice Nurses and Physician Assistants

Introduced by: LSMS

Resolves that the MMA establish a task force to study the issues related to the scope of practice of advanced practice nurses and physi-

Resolutions continued on page 38

Resolutions continued from page 37

cian assistants. It further calls on the MMA to arrange a meeting of the Minnesota Board of Nursing (MBN), the Minnesota Board of Medical Practice (BMP), the Minnesota Nurses Association (MNA), and MMA to arrive at a comprehensive recommendation to the legislature.

Res. 8, Emeritus Physician Advisory Committee

Introduced by: LSMS

Resolves that the MMA adopt a bylaw provision to be effective January 1, 1998, that would require physicians to step down from the position of MMA trustee, MMA officer, or AMA delegate or alternate when they leave active medical practice (more than 20 hours per week working for compensation in a professional activity requiring a degree of Doctor of Medicine or Osteopathy), and further resolves that the MMA establish an emeritus advisory committee of retired and emeritus physicians to offer advice to the MMA Board of Trustees.

Res. 9, Adolescent Access to Tobacco

Introduced by: LSMS

Resolves that the MMA endorse the Minnesota Hospital and Healthcare Partnership's program "STAT" (Stop Teen Access to Tobacco) and encourage MMA members to support initiatives and ordinances to reduce youth access to tobacco in their communities, and it further resolves that the MMA, through its legislative committee and officers, support legislation in 1997 that would set a floor to protect all Minnesota children from access to tobacco and preserve cities' ability to make tobacco access more difficult.

Res. 10, Anti-Smoking Law

Introduced by: Hennepin Medical Society (HMS), Richard K. Simmons, M.D.

Resolves that the MMA publicize the votes of legislators who have voted in favor of tobacco-industry-

supported legislation and against initiatives supported by the Smoke-Free 2000 Coalition, and further resolves that MMA provide information on tobacco-related votes to the Minnesota Medical Political Action Committee and ask that MEDPAC use this information as a key determining factor when deciding candidate endorsements.

Res. 11, Complementary Medicine

Introduced by: HMS, Gary D. Hanovich, M.D.

Resolves that the MMA ask clinical research organizations such as the Health Technology Advisory Committee, the Institute for Clinical Systems Integration, and others to use evidence-based standards to study and validate or reject complementary and alternative health care modalities. It also calls on the MMA to educate members and the public on the outcomes of these studies.

Resolution 12, Appropriate Responsibilities for Licensed Health Care Personnel in Non-Acute Settings

Introduced by: HMS, Richard M. Gebhart, M.D.

Resolves that the MMA work with the MBN, MNA, the Minnesota Licensed Practical Nurse Association (MLPNA), the Minnesota Medical Group Management Association (MMGMA), and the Midwest Medical Insurance Company (MMIC) to develop educational programs and materials that delineate the appropriate functions of all licensed health care professionals in non-acute health care settings such as clinics and physician offices. Programs and materials should address issues such as the supervision of delegated medical functions, nursing functions, and administrative tasks.

Resolution 13, Principles of Collaboration

Introduced by: HMS, John Larsen, M.D., and David Estrin, M.D.

Resolves that the MMA establish parameters to guide the relationship between physicians and medical

organizations including the following issues: 1) contracting standards, 2) physician credentialing standards, 3) physician performance evaluation criteria, 4) data collection and analysis processes and methodologies to evaluate physician performance, 5) affiliation/disaffiliation procedures, 6) due process and mediation procedures, and 7) input into CPT and ICD-9 coding.

Resolution 14, Appropriate Use of Animal Research

Introduced by: HMS, A. Stuart Hanson, M.D., Delegate

Resolves that the MMA take a strong position supporting appropriate and necessary animal research; widely publicize this position; and ask the AMA to do the same.

Resolution 15, Terms Used to Describe Common Medical Care Processes

Introduced by: HMS, A. Stuart Hanson, M.D.

Resolves that the MMA ask the AMA to study the use of terms used to describe common medical care processes in hospital and outpatient settings and make recommendations for the standardization of terms.

Resolution 16, Health Care Financing Administration Guideline

Introduced by: HMS, Virginia R. Lupo, M.D.

Resolves that the MMA urge HCFA to change its interpretation of the final rule regarding staff physician billing for services performed by residents, which requires staff physicians to repeat exams performed by residents, regardless of the level of seniority of the resident and the benign nature of the findings. Changes should be made to avoid requiring the repetition of pelvic exams and to avoid undermining the ascending levels of resident responsibility in medical training. The MMA should work with other organizations such as the AMA, specialty societies, and the Association of American Medical Colleges to seek changes.

Resolution 17, AIDS Testing

Introduced by: Range Medical Society

Resolves that the MMA support legislation that would treat HIV like other communicable diseases.

Resolution 18, Seat Belt Safety

Introduced by: Range Medical Society

Resolves that the MMA support legislation that would increase the fine for failure to wear a seat belt to \$100 for the first offense, \$200 for the second offense, and \$300 for the third offense and that would treat this offense as a moving violation.

Resolution 19, Protective Headgear for Minors While Skiing and Snow Boarding

Introduced by: Range Medical Society

Resolves that the MMA support legislation that would require minors to use protective head gear while skiing and snow boarding in licensed Alpine ski areas.

Resolution 20, Protective Headgear for Minors While Bike Riding, Using ATVs and Snowmobiles

Introduced by: Range Medical Society

Resolves that the MMA support legislation that would require minors to use protective head gear while operating bicycles, ATVs, and snowmobiles.

Resolution 21, Water Safety

Introduced by: Range Medical Society

Resolves that the MMA support legislation to require all minor children to use flotation devices while underway in unnavigable waters in Minnesota (while not on a public water conveyance).

Resolution 22, Parent Education Classes

Introduced by: HMS, Judith F. Shank, M.D.

Resolves that the MMA urge its members to encourage all new par-

ents to participate in parent education classes and that the MMA encourage health systems to provide parent education for their clients in order to raise healthier children and produce a healthier, less violent society.

Resolution 23, Preventive Services Principles

Introduced by: HMS, Eugene Ott, M.D., and Richard Simmons, M.D.

Resolves that the MMA endorse the following statement based on United States Preventive Services Task Force principles:

- Interventions that address patients' personal health practices are vitally important.
- The physician and patient should share decision-making.
- Physicians should take every opportunity to deliver appropriate, effective preventive services, especially to persons with limited access to care.
- For some health problems, community-level interventions may be more effective than clinical preventive services.

Resolution 24, Evidence-Based Health Care

Introduced by: HMS, Eugene Ott, M.D., and Richard Simmons, M.D.

Resolves that the MMA endorse the use of evidentiary, scientific standards in making health care decisions and not support legislative proposals that would mandate standards of care that are not based on evidentiary, scientific standards.

Resolution 25, High-Risk Pregnancy Assessment

Introduced by: HMS, Eugene Ott, M.D., and Richard Simmons, M.D.

Resolves that the MMA endorse the implementation and use of the uniform Minnesota Pregnancy Assessment Form pending MMA evaluation of pilot test results.

Resolution 26, Uniform Credentialing Forms

Introduced by: HMS, Eugene Ott, M.D., and Richard Simmons, M.D.

Resolves that the MMA endorse the implementation and use of uniform credentialing forms by all Minnesota institutions and organizations, including hospitals, that require credentialing information from physicians.

Resolution 27, Eligibility to Serve as MMA Officer, Trustee, AMA Delegate, AMA Alternate Delegate

Introduced by: Ramsey Medical Society (RMS)

Resolves that the MMA amend its bylaws to require physicians to be engaged in active clinical medical practice or other employment as a physician in Minnesota in order to be eligible for election as an MMA officer, trustee, AMA delegate, or alternate. Officers, trustees, and members of the AMA delegation who cease to actively practice medicine or be employed as a physician during their term in office would not be eligible for reelection but could complete their current term.

Resolution 28, WHO Recommendation for Infant Mortality Rate

Introduced by: RMS

Resolves that the MMA call on the AMA to create and support a task force to work with the National Center for Health Statistics and the state statistics units to create a reporting format for the infant mortality rate (IMR) that incorporates World Health Organization (WHO) recommendations and is comparable to the reporting format used in other developed countries so that comparisons of IMR among countries will be accurate and meaningful.

Resolution 29, Reporting HMO Financial Information

Introduced by: RMS

Resolves that the MMA create an ongoing reporting mechanism to study and report annually to the people of Minnesota, via the media, the following information: 1) the rate of reserves of HMOs, health

Resolutions continued on page 40

Resolutions continued from page 39

management companies, hospital systems, and PPOs in the state; 2) the total compensation for leaders and board members of these organizations; and 3) the relationship of compensation and retained earnings to patient premium charges.

Resolution 30, Substitution of Cigarette Tax for 2 Percent Tax

Introduced by: RMS

Resolves that the MMA introduce legislation to repeal the 2 percent provider tax and replace the revenue with an increase in the cigarette tax.

Resolution 31, Defining "Medical Necessity" and Implementing the Uniform Use of the Term

Introduced by: RMS

Resolves that the MMA convene a forum of providers and payers to define "medical necessity" and agree on the uniform application of the term. If the forum fails to reach agreement, the MMA should strongly consider seeking a definitive court ruling on the term "medical necessity" and should call on the AMA to do the same at the national level.

Resolution 32, Section for Employed Physicians

Introduced by: RMS

Resolves that the MMA Board of Trustees consider establishing a section on employed physicians no later than May 1997 and appoint a task force of employed physicians to develop the governing principles for the new section and report to the MMA Board of Trustees in March 1997.

Resolution 33, Ombudsman for Physician Members

Introduced by: RMS

Resolves that the MMA study the possibility of developing an organization, such as a legal services corporation or a legal referral listing, to represent individual physicians who face regulatory and contractual problems, or who have other concerns with the BMP, health plans, employ-

ers, the Minnesota Department of Human Services, Minnesota Department of Health, and other state and federal agencies.

Resolution 34, Study of Point-of-Service Premiums

Introduced by: RMS

Resolves that the MMA study the point-of-service filings of the health plans and the effect of the point-of-service premium rates on the use of point-of-service products by enrollees and the effect on physician providers, and publish a report of its findings and recommendations for further regulatory and/or legislative actions.

Resolution 35, Eliminating Special State Requirements for Medical Licenses and Defining UR as the Practice of Medicine

Introduced by: RMS

Resolves that the MMA work with the AMA and the Federation of State Boards to standardize medical license requirements and eliminate the special state physician license requirements that create barriers for physicians seeking licensure in several states, and it further calls on the MMA to work with the BMP to seek legislation that would define utilization review as the practice of medicine.

Resolution 36, Reimbursement of the 2 Percent Provider Tax

Introduced by: RMS

Resolves that the MMA, prior to the 1997 legislative session, as its No. 1 priority, appoint a task force of physician members, clinic managers, legal counsel, and accounting consultants to study, develop documentation, and prepare a report on the methodology of the collections, pass-through, and reimbursement of the 2 percent provider tax. It further resolves that the MMA take all appropriate measures to implement the task force's recommendations.

Resolution 37, Section for Self-Employed Physicians

Introduced by: RMS

Resolves that the MMA appoint

a task force of self-employed physicians to develop governing principles for an MMA section of self-employed physicians and report to the MMA Board of Trustees in March 1997, and further resolves that the MMA Board of Trustees consider establishing a section on self-employed physicians by May 1997.

Resolution 38, Permits to Carry a Concealed Weapon

Introduced by: ZVMS, Barbara Yawn, M.D.

Resolves that the MMA support the recommendation of the Minnesota chiefs-of-police that issuing permits to carry a concealed weapon remain at the discretion of local law enforcement agencies.

Resolution 39, Racial and Ethnic Disparities in Health Care

Introduced by: MMA Committee on Minority Affairs

Resolves that the MMA support the AMA's efforts to alleviate the disparities in care to minority populations and adopt the recommendations found in the AMA report, "Racial and Ethnic Disparities in Health Care."

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The Monitor

SEPTEMBER 1996

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Timothy J. Crimmins, M.D.

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New Vehicle Leases**

Make/Model***	MSRP	Your Price*	24 Mo	36 Mo	48 Mo	60 Mo
97 GMC Jimmy SLS 4dr	\$26,947	\$24,790	\$464	\$391	\$351	\$337
97 Chevrolet Blazer LS 4dr	\$27,357	\$25,086	\$467	\$394	\$354	\$340
97 Ford Explorer XLT 4dr	\$28,445	\$25,591	\$426	\$364	\$347	\$324
97 Jeep Grand Cherokee Laredo	\$28,188	\$26,099	\$493	\$406	\$366	\$346
96 Nissan Pathfinder SE	\$30,168	\$28,158	\$534	\$440	\$402	\$368
97 GMC Yukon SLE 4dr	\$32,999	\$31,327	\$545	\$478	\$437	\$411
97 Chevrolet Tahoe LS 4dr	\$32,935	\$31,270	\$560	\$488	\$445	\$417
97 Chevrolet Suburban 1/2 LS	\$36,457	\$34,293	\$606	\$515	\$465	\$436
96 Toyota 4-Runner SR5 4dr	\$31,553	\$30,393	\$567	\$485	\$435	\$398
97 Mitsubishi Montero LS 4dr	\$32,642	\$31,225	\$747	\$587	\$502	\$463

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2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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Screening for Tuberculosis Infection Among Secondary School Students in Minneapolis-St. Paul: Policy Implications

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ABSTRACT

Three students in the St. Paul Public Schools were diagnosed with active tuberculosis (TB) in late 1991 and early 1992. To define the prevalence of TB infection in St. Paul and Minneapolis, we conducted school-based screening projects in the St. Paul and Minneapolis public schools during 1992 and 1993. In St. Paul, 7,596 (74.8%) students in grades six through 12 received Mantoux tests; 268 (3.5%) were reactive. Infection rates varied significantly by country of birth, with students born outside the United States more likely to be Mantoux reactors than U.S.-born students (RR=20.2; 95% CI=14.9-27.3; $p<0.001$). In Minneapolis, 752 (47.2%) eighth-grade students received Mantoux tests; 23 (3.1%) were reactive. As in St. Paul, infection rates varied by country of birth; students born outside the United States were more likely to have reactive Mantoux tests than students born in this country (RR=13.2; 95% CI=5.6-31.4; $p<0.001$). We conclude that routine TB screening of school students is not warranted in Minnesota, although school-based screening targeted at the highest risk students, particularly those born outside the United States, may be a beneficial prevention strategy.

Since the mid-1980s, many areas of the United States, including Minnesota, have reported increases in tuberculosis (TB) cases.¹⁻⁵ The rising incidence of TB has been accompanied by significant changes in the epidemiology of TB, including overlap with the HIV epidemic and increasing incidence of TB in difficult-to-reach and recently growing populations (e.g., persons born in regions with a high endemicity of TB, such as Asia, Africa, and Latin America; homeless persons; injecting drug users; and the inner-city poor).⁶⁻⁹

After falling for several decades, the number of TB cases reported in Minnesota reached its lowest level in 1988, with 91 cases (2.1 cases per 100,000 population). Since then, the reported incidence of TB in Minnesota has increased, with 156 new cases (3.4 cases per 100,000 population) reported in 1995. More than half of all TB cases in Minnesota occur in residents of Hennepin and Ramsey counties. In recent years, a varying percentage of TB cases have occurred in children under age 19 years, including 16% and 8% of new cases in 1993 and 1995, respectively (Minnesota Department of Health, unpublished data).

Minnesota's population demographics have changed substantially during the past 20 years.¹⁰ For example, the number of refugees and immigrants arriving from countries with highly endemic rates of TB disease and infection has increased notably. According to 1990 census data, 113,039 (2.6%) Minnesota residents were born outside the United States, 20% of whom entered this country between 1970 and 1979 and 46% between 1980 and 1990. Forty-four percent of Minnesota residents born outside the United States are Asian;

67% of these persons arrived in the United States between 1980 and 1990. Growing numbers of foreign-born persons residing in Minnesota have relocated from a variety of other regions, including Africa, South America, and areas of the former Soviet Union, although these areas each represent less than 5% of Minnesota's foreign-born population.

In accordance with standard public health recommendations, TB screening of Minnesota students was widely practiced until the 1970s, when such screening was gradually discontinued as TB infection rates among students fell to 0.0% to 0.5%.^{11,12} Because of recent changes in the epidemiology of TB and in Minnesota's population demographics, we were interested in determining the current prevalence of TB infection among school-aged children in Ramsey and Hennepin counties. Therefore, we conducted TB screening of students attending St. Paul and Minneapolis public secondary schools during 1992 and 1993.

METHODS

Following the diagnosis of pulmonary TB disease in three students at three different secondary schools in St. Paul between November 1991 and January 1992, extensive TB contact investigations were conducted at each of the three schools during the 1991-92 school year by Saint Paul Public Health and the St. Paul Public Schools, with assistance from the Minnesota Department of Health (MDH).¹³ Given the high proportion of students identified with TB infection who were previously undiagnosed and untreated, the investigators expanded TB screening efforts during the 1992-93 school year to include all students attending the remaining five senior high schools and

Table 1

Rates of TB infection among secondary school students by race and country of birth, St. Paul, 1992-93

	Born outside U.S.		Born in U.S.		Total*	
Race†	No. reactors†/ No. screened	(%) (95% CI)	No. reactors†/ No. screened	(%) (95% CI)	No. reactors†/ No. screened	(%) (95% CI)
Asian	172/1131	(15.2) (13.2, 17.4)	1/269	(0.4) (0.0, 2.1)	173/1410	(12.3) (10.6, 14.1)
White	35/151	(23.2) (16.7, 30.7)	38/4724	(0.8) (0.6, 1.1)	73/4955	(1.5) (1.2, 1.9)
Black	8/36	(22.2) (10.1, 39.2)	10/912	(1.1) (0.5, 2.0)	18/970	(1.9) (1.1, 2.9)
Native American	1/6	(16.7) (0.4, 64.1)	0/142	(0.0) (0.0, 2.6)	1/150	(0.7) (0.0, 3.7)
Unknown	2/4	(50.0) (6.8, 93.2)	1/106	(0.9) (0.0, 5.1)	3/111	(2.7) (0.6, 7.7)
Total	218/1328	(16.4) (14.5, 18.5)	50/6153	(0.8) (0.6, 1.1)	268/7596	(3.5) (3.1, 4.0)

*Total number of students screened includes 115 students for whom country of birth was unknown; none of these students were Mantoux reactors.

†A reactor was defined as a student with a Mantoux result measuring 10mm or greater of induration.

‡Ethnicity data are not available.

12 junior high schools in the St. Paul Public School District.

To further define the prevalence of TB infection in the Twin Cities metropolitan area, MDH, in cooperation with the Minneapolis Public Schools, the Hennepin County Community Health Department, and the Minneapolis Department of Health and Family Support, conducted TB screening of eighth-grade students at four of the six middle schools in the Minneapolis Public School District

during October and November 1993. These schools were selected on the basis of the race/ethnicity and socioeconomic status of their student populations, which were representative of the overall middle school population in the district.

To accomplish the TB screening projects in both school districts, school-based Mantoux testing clinics were conducted by school nurses, local public health nurses, and other public health staff. Nurses adminis-

tered Mantoux tests according to the package insert using Tubersol®, an intradermal purified protein derivative tuberculin preparation manufactured by Connaught Laboratories Limited (Willowdale, Ontario, Canada). Nurses at the school-based clinics read the Mantoux tests 48 to 72 hours after placement and recorded millimeters (mm) of induration of the Mantoux reactions. An induration of 10mm or greater was considered a reactive Mantoux result. A

history of prior *Bacillus Calmette-Guerin* (BCG) vaccination was disregarded for the interpretation of Mantoux results.

Demographic data, including date of birth, gender, race/ethnicity (collected only in Minneapolis), country of origin, and school attended, were elicited from school district records and from students at the time of screening. Written parental consent and the student's history of previous reactive tuberculin skin tests were obtained before Mantoux tests were administered. Students with previous reactive Mantoux test results were excluded from school-based screening. In St. Paul, parents also were given the option of having their children screened at any clinic outside the school and providing Saint Paul Public Health with the results. Results of Mantoux tests administered outside the school-based clinics were included in the St. Paul study after being verified by the health care providers.

Parents of students with reactive Mantoux tests received letters encouraging them to seek follow-up medical evaluation for their children. Referrals were made to either the local public health TB clinic or the students' private physicians. Postcards requesting follow-up information (history of BCG vaccination, personal and family history of TB disease, history of previous Mantoux tests, chest x-ray results, and treatment with isoniazid [INH]) were enclosed with the parental notification letters; postcards were pre-addressed to the public health department. Parents were asked to give the postcards to their children's health care providers at the time of the follow-up clinic visits. Additionally, in the Minneapolis project, records at the local public health TB clinic and the MDH TB Control Program were searched for follow-up information on students who had reactive Mantoux tests during the screening project but for whom postcards were not returned.

STATISTICAL ANALYSES

Data were analyzed using standard univariate methods provided by Epi Info (Chi square test and Chi square

Table 2

Rates of TB infection among secondary school students by country of birth, St. Paul, 1992-93

Country or region of birth	No. reactors* / No. screened	(%)
Central or South America	25/81	(30.9)
Africa	7/27	(25.9)
Europe	12/75	(16.0)
Asia	173/1130	(15.3)
Australia or Canada	1/15	(6.7)
United States	50/6153	(0.8)
Unknown	0/115	(0.0)
Total	268/7596	(3.5)

* A reactor was defined as a student with a Mantoux result measuring 10mm or greater of induration.

test for trend).¹⁴ Confidence intervals were calculated based on a binomial distribution using True Epistat statistical software.¹⁵

RESULTS

ST. PAUL PUBLIC SCHOOLS

Of 10,155 students enrolled at the 17 St. Paul secondary schools included in the screening program, 7,596 (74.8%) received Mantoux tests. Participation rates varied by school, ranging from 48.6% to 91.9%. Participation rates were inversely related to grade level, with 79.7% participation among sixth-grade students and 70.3% participation among 12th-grade students. Participation rates also varied by race, ranging from 55.1% for black students to 81.6% for Asian students. The participation rate was higher for stu-

dents born outside the United States (81.3%) than for students born in this country (74.0%).

Overall, 268 (3.5%) students had reactive Mantoux tests (either as a result of the school-based screening or according to validated histories of previous reactive tests). TB infection rates varied by country of birth (see Table 1); students born outside the United States were significantly more likely to have a reactive Mantoux test (16.4%) than students born in the United States (0.8%) (Relative Risk [RR]=20.2; 95% Confidence Interval [CI]=14.9-27.3; $p<0.001$). In addition, TB infection rates varied by country of birth for students born outside the United States (see Table 2). The prevalence of TB infection increased significantly with increasing age among students born outside the United States (Chi square=37.2;

Table 3

Rates of TB infection among secondary school students by age and country of birth, St. Paul, 1992-93

Age (years)	Born outside U.S.		Born in U.S.		Total*	
	No. reactors [†] / No. screened	(%) (95% CI)	No. reactors [†] / No. screened	(%) (95% CI)	No. reactors [†] / No. screened	(%) (95% CI)
10-14	49/485	(10.1) (7.6, 13.1)	23/3408	(0.7) (0.4, 1.0)	72/3968	(1.8) (1.4, 2.3)
15-19	137/755	(18.1) (15.5, 21.1)	27/2739	(1.0) (0.7, 1.4)	164/3534	(4.6) (4.0, 5.4)
20-24	32/88	(36.4) (26.4, 47.3)	0/6	(0.0) (0.0, 45.9)	32/94	(34.0) (24.6, 44.5)
Total	218/1328	(16.4) (14.5, 18.5)	50/6153	(0.8) (0.6, 1.1)	268/7596	(3.5) (3.1, 4.0)

*Total number of students screened includes 115 students for whom country of birth was unknown; none of these students were Mantoux reactors.

[†]A reactor was defined as a student with a Mantoux result measuring 10mm or greater of induration.

$p < 0.001$) but not for students born in this country (Chi square=1.75; $p=0.19$) (see Table 3).

Fifty students with reactive Mantoux tests were born in the United States. Millimeters of induration were recorded for 45 of these 50 students; 31 (69%) had reactions measuring 10mm to 14mm, and 14 (31%) had reactions of 15mm or greater. State of birth was known for 47 of the 50 students; 33 (70%) were born in Minnesota.

Of the 268 students with reactive Mantoux tests, 139 (52%) had been identified previously as having TB infection, based on either histories reported before the school-based screening or follow-up data collected after such screening; 109 (78%) of these students had completed adequate preventive therapy. Eighty-nine (41%) of 218 students who had reactive Mantoux tests and who were

born outside the United States had been identified and treated in the past, and 20 (40%) of 50 students who had reactive tests and who were born within the United States had been identified and treated. Thus, 129 (48%) of 268 students with reactive Mantoux tests overall had not been identified by routine clinical screening or public health activities, and 159 (59%) students had not received adequate prophylaxis. No cases of active TB were identified as a result of the screening.

Of the 159 Mantoux reactors who had not completed adequate prophylaxis, 149 (94%) received a follow-up chest x-ray; none was consistent with active TB disease. Of these 159 students, 108 (68%) completed at least six months of INH preventive therapy following the screening project, 12 (8%) began preventive therapy but failed to com-

plete an adequate regimen, 12 (8%) received follow-up medical evaluation but were not placed on preventive therapy, and follow-up data were not available for 27 (17%) students.

MINNEAPOLIS PUBLIC SCHOOLS

Of 1,593 eighth-grade students enrolled at the four Minneapolis public schools selected for TB screening, 752 (47.2%) participated in the screening program. Participation rates varied by school (41.6% to 57.8%) and students' race/ethnicity (29.3% among Native American students to 66.2% among white students).

Of the 752 students screened, 23 (3.1%) had reactive Mantoux tests. Similar to the findings in St. Paul, TB infection rates in Minneapolis students varied by country of birth (see Table 4). Students born outside the United States were significantly more

Table 4

Rates of TB infection among secondary school students by race and country of birth, Minneapolis, 1993

	Born Outside U.S.		Born in U.S.		Total	
Race/ Ethnicity	No. Reactors* / No. Screened	(%) (95% CI)	No. Reactors* / No. Screened	(%) (95% CI)	No. Reactors* / No. Screened	(%) (95% CI)
Asian	12/84	(14.3) (7.6, 23.6)	1/16	(6.3) (0.2, 30.2)	13/100	(13.0) (7.1, 21.2)
White	0/6	(0.0) (0.0, 45.9)	2/342	(0.6) (0.1, 2.1)	2/348	(0.6) (0.1, 2.1)
Black	3/17	(17.6) (3.8, 43.4)	4/244	(1.6) (0.5, 4.1)	7/261	(2.7) (1.1, 5.5)
Hispanic	1/4	(25.0) (0.6, 80.6)	0/20	(0.0) (0.0, 16.8)	1/24	(4.2) (0.1, 21.1)
Native American	0/0	(—) (—)	0/19	(0.0) (0.0, 17.7)	0/19	(0.0) (0.0, 17.7)
Total	16/111	(14.4) (8.5, 22.4)	7/641	(1.1) (0.4, 2.2)	23/752	(3.1) (2.0, 4.6)

*A reactor was defined as a student with a Mantoux result measuring 10mm or greater of induration.

likely to have a reactive Mantoux test (14.4%) than students born in this country (1.1%) (RR=13.2; 95% CI=5.6-31.4; $p<0.001$). Of the 16 students with reactive Mantoux tests who were born outside the United States, 10 (63%) were born in Southeast Asia, three (19%) in Africa, one (6%) in Central America, one (6%) in South America, and one (6%) in Western Europe.

Infection rates in students born in the United States were similar at each of the four schools, ranging from 0.0% to 1.8%. However, infection rates in students born outside the United States were considerably higher at two schools (20.7% and 10.5%) than at the remaining two

schools (0.0% for both schools). The former two schools have Limited English Proficiency (LEP) programs, which predominantly enroll students who have arrived recently in this country. The latter two schools do not have LEP programs or the associated populations of students new to this country.

Of seven students with reactive Mantoux tests who were born in the United States, four (57%) had Mantoux reactions of 15mm or greater, including one student whose Mantoux reaction measured 95mm. (This student had been identified previously through a contact investigation surrounding a TB case but had not been located for testing prior to the

school screening project.) Also, one student was born in Minnesota but lived in Afghanistan for several years. Among students born in the United States, those who had lived outside Minnesota were no more likely to have a reactive Mantoux test (1.7%) than students who never had resided outside the state (0.7%) (RR=2.3; 95% CI=0.5-10.2; $p=0.3$).

Before the school-based screening, 12 students reported a previous reactive Mantoux test, which was confirmed through medical records. These students were not retested, and they are not included in the overall prevalence of TB infection reported here, since the prevalence calculation was based on those tested as part of

this project. Of these 12 students, 10 (83%) received chest x-rays following their reactive Mantoux tests; none had evidence of TB disease. Five (42%) of the 12 students had completed adequate preventive therapy prior to the school-based screening, five (42%) were currently taking preventive therapy medication, and two (17%) had not received adequate TB prophylaxis.

Follow-up data were available for 18 (78%) of the 23 Mantoux reactors identified during the screening project. Of these 18 students, four (22%) had completed at least six months of INH preventive therapy prior to the screening project, one (6%) had completed adequate therapy for active TB disease, and one (6%) was currently taking preventive therapy. (These students' parents had not identified such histories on consent forms, so the students were screened again as part of this project.) Of the 12 remaining students for whom follow-up data were available, 11 (92%) were medically evaluated and identified as candidates for prophylaxis. Nine (82%) students began INH preventive therapy following the screening project, and the remaining two students failed appointments with private physicians and were not placed on preventive therapy.

DISCUSSION

The findings described here are similar to those of other population-based TB screening projects in children and young adults in the United States and Canada. In 1990, the prevalence of TB infection among male U.S. Navy recruits was 2.5% overall, 1.6% among U.S.-born recruits, and 19.2% among recruits born elsewhere.¹⁶ During 1992, students were screened for TB in Toronto, Ontario, following the diagnosis of TB in 10 children from an extended family. Among students at the two schools attended by students with TB disease, infection rates were 1.2% in Canadian-born students and 14.6% in students born outside Canada. At three comparison schools with no known TB cases, infection rates were 0.4% in Canadian-born students and 9.8% in students born elsewhere.¹⁷

Current TB screening guidelines from the Centers for Disease Control and Prevention (CDC) define a reactive Mantoux test in low-risk populations as at least 15mm of induration.^{18,19} In the St. Paul and Minneapolis school screening projects described here, many students classified with reactive Mantoux tests who were born in the United States had Mantoux results with induration measuring 10mm to 14mm. While some of these students would be considered high-risk for TB because of residence in inner-city neighborhoods of relatively low socioeconomic status, many do not fit any defined high-risk category. It is possible that some of these students had false positive Mantoux tests; thus, the true prevalence of TB infection among U.S.-born students may have been lower than the reported rates of 0.8% in St. Paul and 1.1% in Minneapolis.

Screening participation rates varied by school, race/ethnicity, and country of birth. Participation rates among non-white groups were generally lower than those among white students, although Asian students had the highest participation rate in St. Paul. In both St. Paul and Minneapolis, participation rates among students born outside the United States exceeded those among students born in the United States. It is possible that the highest-risk students were underrepresented among participants, thereby artificially lowering the reported prevalence of TB infection. However, the consistency of the data between St. Paul and Minneapolis, both within racial groups and overall, suggests that the reported results are representative of the populations studied. St. Paul and Minneapolis public school students likely represent those students in Minnesota at highest risk of TB infection, based on demographics and other risk factors. The low overall prevalence of TB infection and the dramatic variation in prevalence by country of birth likely persists throughout the state.

For students born outside the United States, TB infection rates increased directly with age. This trend would be unexpected if Mantoux reactions in this group were due predominantly to cross-reactivity from

BCG vaccination at an early age (which wanes over time).^{18,20,21} Instead, it is possible that older students resided in their countries of origin longer than younger students, thereby increasing their risk of acquiring TB infection. This hypothesis is supported by the higher rates of TB infection in those Minneapolis schools with LEP programs enrolling students newly arrived in the United States.

The American Academy of Pediatrics recommends annual screening of children at high risk for TB infection.^{22,23} Considered high-risk are "children who are from, or who have parents who are from, regions of the world with a high prevalence of TB infection" and "children who are frequently exposed to the following adults: HIV-infected individuals, homeless persons, users of intravenous and other street drugs, poor and medically indigent city dwellers, residents of nursing homes, and migrant farm workers."

The academy's recommendation is supported by a recent study by Mohle-Boetani et al. comparing the costs and benefits of screening all kindergartners and ninth-grade students versus screening only high-risk students born outside the United States in countries with a high prevalence of TB. The study was conducted in Santa Clara County, California, where TB screening of all kindergartners and ninth-grade students was mandated in 1989. The estimated prevalence of TB infection among high school students was 29% for high-risk students and 2.4% for students born in the United States. A cost-benefit analysis compared direct medical costs of TB screening to costs saved by preventing TB cases. The investigators concluded that universal screening (which would prevent 14.9 cases of TB per 10,000 children screened) is more costly than no screening, whereas targeted screening (which would prevent 84.8 cases of TB per 10,000 children screened) would result in a net savings.^{11,12}

CONCLUSION

Universal TB screening of students is not warranted in Minnesota based on the low overall prevalence of TB

infection among students screened at public schools in St. Paul and Minneapolis. Most TB infection in this population occurred in students born outside the United States; children born in the United States were at low risk for TB infection. Furthermore, many students with reactive Mantoux tests who were born outside the United States had not been identified previously by such means as other public health programs or routine provider-based screening. Therefore, school-based TB screening targeted at the highest-risk students may provide access to such populations. In the absence of data regarding ongoing transmission within local communities, it is not clear how frequently students born outside the United States should be screened for TB; at a minimum, these children should be screened at least once. A reasonable approach is to screen children born outside the United States upon arrival in Minnesota and periodically thereafter, at intervals such as at age 1, at school entry, and once during adolescence.

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REFERENCES

1. Cantwell MF, Snider DE, Cauthen GM, Onorato IM. Epidemiology of tuberculosis in the United States, 1985 through 1992. *JAMA* 1994;272:535-9.
2. Snider DE, Roper WL. The new tuberculosis. *N Engl J Med* 1992;326:703-5.
3. Brudney K, Dobkin J. Resurgent tuberculosis in New York City: human immunodeficiency virus, homelessness, and the decline of tuberculosis control programs. *Am Rev Respir Dis* 1991;144:745-9.
4. Joseph S. Editorial: tuberculosis, again. *Am J Public Health* 1993;83:647-8.
5. Starke JR, Jacobs RF, Jereb J. Resurgence of tuberculosis in children. *J Pediatr* 1992;120:839-55.
6. American Thoracic Society, Centers for Disease Control, Infectious Disease Society of America. Control of tuberculosis in the United States. *Am Rev Respir Dis* 1992;146:1623-33.
7. Centers for Disease Control and Prevention. Initial therapy for tuberculosis in the era of multidrug resistance: recommendations of the Advisory Council for the Elimination of Tuberculosis. *MMWR* 1993;42 (No. RR-7):1-8.
8. KcKenna MT, McCray E, Onorato I. The epidemiology of tuberculosis among foreign-born persons in the United States, 1986 to 1993. *N Engl J Med* 1995;332:1071-6.
9. Raviglione MC, Snider DE, Kochi A. Global epidemiology of tuberculosis: morbidity and mortality of a worldwide epidemic. *JAMA* 1995;273:220-6.
10. Bureau of the Census. 1990 Census of population: social and economic characteristics: Minnesota. Washington, D.C.: Economic and Statistics Administration, U.S. Department of Commerce, 1990. CP-2-25:82-4.
11. Mohle-Boetani JC, Miller B, Halpern M, et al. School-based screening for tuberculous infection: a cost-benefit analysis. *JAMA* 1995;274:613-9.
12. Starke JR. Universal screening for tuberculosis infection: school's out! *JAMA* 1995;274:652-3.
13. Minnesota Department of Health. Tuberculosis in St. Paul schools. *Disease Control Newsletter* 1992;20:61-3.
14. Dean AG, Dean JA, Coulombier D. Epi Info, Version 6: a word processing, database, and statistics program for epidemiology on microcomputers. Atlanta, Georgia: Centers for Disease Control and Prevention, 1994.
15. Gustafson T. True Epistat. Richardson, Texas: Epistat Services, 1994.
16. Trump DH, Hyams KC, Cross ER, Struwing JP. Tuberculosis infection among young adults entering the US Navy in 1990. *Arch Intern Med* 1993;153:211-6.
17. Rothman LM, Dubeski G. School contact tracing following a cluster of tuberculosis cases in two Scarborough schools. *Can J Public Health* 1993;84:297-302.
18. Huebner RE, Schein MF, Bass JB. The tuberculin skin test. *Clin Infect Dis* 1993;17:968-75.
19. American Thoracic Society, Centers for Disease Control and Prevention. Treatment of tuberculosis and tuberculosis infection in adults and children. *Am J Respir Crit Care Med* 1994;149:1359-74.
20. Centers for Disease Control and Prevention. Use of BCG vaccines in the control of tuberculosis: a joint statement by the ACIP and the Advisory Committee for Elimination of Tuberculosis. *MMWR* 1988;37:663-4, 669-75.
21. Ciesielski SD. BCG vaccination and the PPD test: what the clinician needs to know. *J Fam Pract* 1995;40:76-80.
22. American Academy of Pediatrics. Tuberculosis. In: Peter G, ed. 1994 red book: report of the Committee on Infectious Diseases. 23rd ed. Elk Grove Village, Illinois: American Academy of Pediatrics, 1994:486.
23. Committee on Infectious Diseases, American Academy of Pediatrics. Screening for tuberculosis in infants and children. *Pediatr* 1994;93:131-4.

Assessing Immunization Rates and Improving Practices

CASA and the 'Key Steps' Model

Physician clinics can assess and improve immunization rates by using standard software and guidelines obtainable through the Minnesota Department of Health.

Teresa Asper Anderson, D.D.S., M.P.H., and Margo Roddy, M.P.H.

INTRODUCTION

Clinic-based immunization assessments are an important clinic activity. They measure clinic immunization rates and can reveal areas that need improvement. Clinic Assessment Software Application (CASA) is a standardized measurement and analysis tool developed by the Centers for Disease Control and Prevention for this purpose. Also useful is the companion guide, "Key Steps in Assessing Clinic Immunization Levels and Practice," produced by the Minnesota Department of Health.

From September 1995 to May 1996, the Saint Paul Immunization Action Plan used CASA to help 12 clinics assess their preschool immunization rates. The percentage of 24-month-old children who had received four DTPs, three OPVs, and one MMR ranged from 23% to 75%, with a clinic average of 49.4%. The assessment process provided participants with valuable information for improving immunization practices. CASA and the "Key Steps" guide are available to providers at no charge through the Minnesota Department of Health.

Immunization is our most powerful and cost-effective method for protecting children against vaccine-preventable diseases. However, there are pockets of underimmunized children throughout Minnesota. Various surveys have identified parental barriers to age-appropriate immunization, but removing such barriers is only part of the solution. Provider practices also significantly affect immunization levels within a given clinic. Accordingly, one way for clinics to start making sustainable practice changes is by assessing their own immunization levels.¹ (The Minnesota Department of Health's recommended childhood immunization schedule appears on page 52.)

The Advisory Committee on Immunization Practices (ACIP) recommends regular assessment of vaccination rates "to motivate providers and staff to improve vaccination practices."² Standard number 14 in the national Standards for Pediatric Immunization Practices states that both public and private providers should conduct semiannual audits to assess immunization coverage lev-

els in their practices.³ Several studies have found that regular assessment of vaccination rates is an effective method for achieving improved, sustainable immunization coverage. For example, when the state of Georgia began a program in 1986 to annually assess the vaccination records of children enrolled in public clinics, their up-to-date immunization rate for 2-year-old children rose from less than 40% to 80% by 1994.² Other surveys of private and managed care practices in several states indicate that assessment improved immunization levels in these settings.^{2,4,5}

One of the tools available to providers for this purpose is the Clinic Assessment Software Application. CASA is an easy-to-use, DOS-based computer program developed by the Centers for Disease Control and Prevention (CDC) and distributed by the Minnesota Department of Health (MDH). CASA provides a standardized analysis tool that also identifies the data to be collected and the number of charts to be reviewed. In addition to calculating immunization rates for different age groups or vaccine combinations, CASA can identify "missed opportunities" and even generate recall letters or postcards for children who are behind schedule. The computer requirements are minimal and include a 286 IBM-compatible computer with 450K RAM, version 3.31 of DOS, and at least 3 MB of disk space.

In addition, MDH developed the guide "Key Steps in Assessing Clinic Immunization Levels and Practices" as a companion piece to the CASA software. The "Key Steps" guide offers a clear methodology when clinic managers ask, "How do we implement CASA?"

The "Key Steps" guide includes information about planning and coordinating the assessment, for example, what to consider before beginning. One of the most important questions to ask before conducting an audit is: "Which children should be included in the assessment?" The "Key Steps" guide provides a standard definition for record eligibility to ensure that immunization data are representative and comparable between sites. The first requirement of eligibility is age: CASA can be programmed to assess the shots of children of any age, but

the recommended age group is 2 to 3 years of age (24 to 36 months), making it possible to calculate the percentage of children up-to-date for *all* the recommended preschool immunizations. While an assessment that includes younger children would provide more timely information, i.e., would include more recently administered shots, it would be limited to providing data for only

part of the cohort's primary series. For example, a clinic assessment using a group of 6-month-old children would only yield data for the doses required at 2 and 4 months of age.

Next, the assessor must decide how to define an active patient within the target age range. The "Key Steps" guide outlines two different definitions for an

Four Steps to Improving Immunization Rates

The concept of continuous quality improvement may seem overwhelming to small practices—and many larger ones, too. Clinical Assessment Software Application (CASA) and an immunization chart review (audit) may provide the perfect opportunity to succeed in your first attempt to implement CQI in your practice—and you'll end up with a better immunization rate.

1. Determine the problem. Immunizations are effective preventive medicine, and immunization rates in young children are too low. We have had epidemics in Minnesota.

2. Develop a strategy to assess the problem in your practice. CASA and the companion "Key Steps" guide produced by the Minnesota Department of Health outline the steps for you to complete your assessment: selecting eligible subjects, choosing the correct number to assure your results are representative, determining what data to collect, and analyzing your information. The process still requires someone to obtain the data and enter it into the computer, but this is less overwhelming when the other steps are outlined for you.

3. Identify the strengths and weaknesses in your practice's immunization program. This requires the time and expertise of you and your staff. Teresa Anderson and Margo Roddy, authors of the accompanying article, suggest you'll want to be able to answer certain questions:

- Do children start immunizations on time and then get behind as more shots are required? Is there an age, such as 12 months, when children seem to stop coming for immunizations?

- Are the rates different for different immunizations? For example, do children seem to always miss the later shots, such as the MMR, or the early ones, such as the hepatitis B?

- Is your clinic missing opportunities to immunize children by not using combination vaccines or not immunizing children with minor illnesses?

The queries shouldn't end with the quantitative data. When looking at the charts, assess the quality of record-keeping. Inadequate immunizations can be related to inadequate documentation. Was the

immunization information easy to find? Could you find it in all charts? Were parental refusals documented? Were adverse reactions documented and easy to find?

4. Develop a plan to overcome weaknesses and solidify strengths. Include a broad range of people in discussions to develop better, more functional solutions. Authors Roddy and Anderson point out that, again, CASA and the "Key Steps" guide can be useful.

- Children who drop out after two or three immunizations may benefit from a reminder card. Does your practice keep track of who is due for an immunization, or do you just wait for the parents and child to return?

- Do you call parents to reschedule children who have missed appointments or who were too ill to receive immunizations when they came in? Do you work with local public health agencies to locate hard-to-reach parents of children who are underimmunized?

- What is your policy on immunizing children with mild illnesses? How do you educate parents to assure them it is safe to immunize children with colds or ear infections and only low-grade fevers?

- Is everyone in the practice using the same immunization schedule? Which schedule should you select?

Currently, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Advisory Committee on Immunization Practices have a common schedule they recommend (see page 52). The method of providing polio immunizations is under discussion, but all groups agree that polio immunizations should be given at the times outlined.

Whether you call it CQI or just assessing and improving your practice, try looking at childhood immunizations. CASA, the "Key Steps" guide, and the work of people like the Saint Paul Immunization Action Plan staff and St. Paul immunization providers should make it easier.

—Barbara P. Yawn, M.D., M.Sc., Section Editor, with the assistance of Teresa Anderson, D.D.S., M.P.H., and Margo Roddy, M.P.H.

Recommended Childhood Immunization Schedule Minnesota, 1996

Bars indicate range of acceptable ages; shaded bars indicate catch-up vaccination. Vaccines below dotted line are for selected populations.

Vaccine ▼	Age ►	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	2 yrs	4-6 yrs	11-12 yrs	14-18 yrs
Hepatitis B ^{1,2}		HBV-1										HBV ² (1-3)	
		HBV-2			HBV-3								
Diphtheria, Tetanus, Pertussis ³			DTP	DTP	DTP	DTP ³ (DTaP at 15+mos.)					DTaP or DTP	Td	
<i>Haemophilus influenzae</i> type b ⁴			Hib	Hib	Hib ⁴	Hib ⁴							
Polio ⁵			OPV ⁵	OPV	OPV						OPV		
Measles, Mumps, Rubella ⁶						MMR					MMR ⁶		
Varicella ⁷						Varicella				Varicella ⁷			
Hepatitis A ⁸										HAV ⁸			
Influenza ⁹					Influenza								
Pneumococcal ¹⁰										Pneumococcal			

Footnotes

- Hepatitis B (Infants):** Infants born to HBsAg-negative mothers should receive 2.5 µg of Merck vaccine (Recombivax HB) or 10 µg of SmithKline Beecham (SB) vaccine (Engerix-B). Administer a 2nd dose ≥1 month after the 1st dose and a 3rd dose at 6-18 months of age. Infants born to HBsAg-positive mothers should receive 0.5 mL Hepatitis B Immune Globulin (HBIG) within 12 hours of birth, and either 5 µg of Recombivax HB or 10 µg of Engerix-B at a separate site. The 2nd dose is recommended at 1-2 months of age and the 3rd dose at 6 months of age. Infants born to mothers whose HBsAg status is unknown should receive either 5 µg of Recombivax HB or 10 µg of Engerix-B within 12 hours of birth. The 2nd dose of vaccine is recommended at 1 month of age and the 3rd dose at 6 months of age.
- Hepatitis B (Adolescents):** Adolescents who have not previously received 3 doses of hepatitis B vaccine should initiate or complete the series at about 11-12 years of age. The vaccine may be administered at 0, 1, 6 months; 0, 1, 4 months; or 0, 2, 4 months.
- Diphtheria, Tetanus, Pertussis:** DTP-4 may be administered as early as 12 months of age, provided at least 6 months have elapsed since DTP-3. DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) is licensed for use for the 4th and/or 5th dose of DTP vaccine in children 15 months of age or older and is preferred to reduce the chance of local reactions and fever that often follow whole-cell DTP, particularly in older-aged children. Children who have a true contraindication to whole-cell pertussis vaccine should receive DT (which is for pediatric use) and not DTP or DTaP. Td (tetanus and diphtheria toxoids, adsorbed, for adult use) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP, or DT.
- Haemophilus influenzae* type b:** Three Hib conjugate vaccines are licensed for infant use. Note that if PRP-OMP (PedvaxHIB® from Merck) is administered at 2 and 4 months of age, a dose at 6 months is not required. After completing the primary series, any Hib conjugate vaccine may be used as a booster.
- Polio:** Oral poliovirus vaccine (OPV) is recommended for routine infant vaccination; inactivated poliovirus vaccine (IPV) is an acceptable alternative. IPV is recommended for persons with a congenital or acquired immune deficiency disease or an altered immune status as a result of disease or immunosuppressive therapy and for children who have household or close contacts with these conditions. A 4-dose series of IPV should be given with a minimum interval of 4 weeks between the 1st and 2nd doses and 6 months between the 2nd and 3rd doses followed by a booster dose before entering school.
- Measles, Mumps, Rubella:** While it is preferable to provide MMR-2 to children at about 11-12 years of age, the 2nd dose may be given any time after the child reaches 4 years of age.
- Varicella:** Varicella vaccine should routinely be administered to susceptible children at 12-18 months of age. Unvaccinated children ≥18 months who lack a reliable history of chickenpox should also be vaccinated. Children ≤12 years should receive one dose; those ≥13 years should receive 2 doses 4-8 weeks apart.
- Hepatitis A:** Hepatitis A vaccine should be administered to children and adolescents at increased risk of infection and may be considered for all other persons over 2 years of age wishing to obtain immunity. Children should receive 1-2 doses, depending on the product given, and a booster dose ≥ 6 months after the initial dose. Consult package insert for specific scheduling and dosing information.
- Influenza:** Influenza vaccine should be administered annually to children 6 months of age and older who have specific risk factors. Children 12 years and younger should receive split virus vaccine in a dosage appropriate for their age (0.25 mL if 6-35 months or 0.5 mL if 3 years or older). Children less than 9 years of age who are receiving influenza vaccine for the first time should receive 2 doses, separated by at least 1 month.
- Pneumococcal:** Pneumococcal vaccine should be administered to children 2 years of age and older who have increased risk of acquiring systemic pneumococcal infections or increased risk of serious disease if they become infected. Children ≤10 years of age who previously received the 23-valent vaccine should be considered for revaccination after 3-5 years if they are at high risk of severe pneumococcal infection; children >10 years with these conditions should also be revaccinated if it has been ≥6 years since their first vaccination.

Based on recommendations of the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians, and the Immunization Practices Task Force of the Minnesota Department of Health (MDH)

Questions? Call the MDH, (612)623-5237 or toll-free, (800) 657-3970.

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active or eligible record. The recommended definition is any child ever seen at or assigned to the clinic by a prepaid health plan. This includes all children with medical records at the clinic. For clinics with assigned managed care patients, the definition includes those children who have been pre-assigned by a prepaid health plan even if they have never presented for care.

The second, or interim, definition for an eligible record is visit-based and includes those children with two or more visits to the clinic during the first two years of life. This is a more flexible definition for those clinics providing many acute or urgent care visits. It is important to remember that the chosen record definition greatly influences the resulting immunization rates. The real danger lies in making the eligibility criteria so narrow that the resulting coverage rates are artificially high, masking existing problems.

Whether using the recommended or the interim definition, only those children with absolute confirmation that they have moved, died, or gone elsewhere for health care before their second birthday should be excluded from the assessment. An out-of-state forwarding address or a letter requesting records be transferred to a new provider are examples of such confirmation.

CASA allows for customized reports, and clinics desiring specialized reports should plan ahead to collect and enter the necessary data. Immunization rates can be calculated separately by insurance plan, by ZIP code, by provider name, by race, or virtually anything else desired, as long as the data are available in the chart and entered into the CASA program. However, an adequate number of children must be included within each category to obtain meaningful results.

The required information that must be abstracted and entered into the CASA program, i.e., the minimum data set, are the child's name or other identifier, the date of birth, the shot type, and the shot date. CASA calculates missed opportunities if the diagnosis for every visit and the child's temperature are abstracted from the record. If the patient's address is entered, CASA can generate personalized letters or postcards to the parent of each child behind schedule.

Once all the preliminary decisions have been made, the actual chart review can begin. In June 1995, Saint Paul Immunization Action Plan (IAP) offered to help conduct a free and confidential practice assessment for any provider in the St. Paul area. From September 1995 through May 1996, IAP staff assisted 12 clinics in reviewing their immunization records. Among the clinics were six private offices (either pediatric or family medicine), five community clinics, and Saint Paul Public Health's primary care clinic.

METHODS

For the chart reviews, the clinics followed the recommended guidelines for age eligibility, choosing to assess the immunization histories of children 24 to 36 months of age. All the clinics used common dates for pulling age-eligible charts: children born on or between September 6, 1992, and September 5, 1993.

An active record was one for any child who had at least two visits to the clinic prior to age 2, unless there was absolute confirmation that the child had died, moved, or transferred to another clinic.

To estimate how many children were in this age range at each site, many clinics used computerized billing records. If this method wasn't available, the clinic manually counted charts or counted the number of eligible charts in a section of shelving and then multiplied that number by the number of sections.

The clinics used CASA to determine the number of charts to review based on the estimate of the total number of 2-year-olds within each practice. If a practice had fewer than 200 eligible children, all charts were included in the analysis; otherwise CASA generated the necessary number.

One of the largest clinics had 750 eligible children, according to data from billing records, and CASA calculated that 188 charts should be pulled, starting with the second eligible chart and selecting every fourth eligible chart thereafter.

The data from about 50 charts could be abstracted in three hours. Most clinics completed the chart reviews in two half-day sessions with minimal disruption to their ongoing activities. All vaccines recommended during the time period were recorded. *Haemophilus influenzae* type b (Hib) and hepatitis B immunizations were assessed independently and also in combination with the other required vaccines. To be included in the assessment, each vaccine dose needed to have had a documented date recorded.

RESULTS

A total of 994 charts (451 charts reviewed at public/community clinics and 543 reviewed at private providers) were abstracted and the data entered into CASA. The 24-month up-to-date rate for four DTP, three OPV, and one MMR at these 12 clinics ranged from 23% to 75%, with an average of 49.4%. The average for the six public/community clinics was 46.5%, and the six private clinics had an average of 52.3%.

The number of children completing all required immunizations declined as the number of immunizations increased from a single OPV and DTP to the full series. There was an average drop-out rate of 30% between those children starting with DTP1 during their first year and those finishing with DTP4 by age 2. Completion of the first dose of MMR by 24 months was only 65.6%. Twenty-one percent of all clinic visits for children less than age 2 involved a missed opportunity for immunization.

DISCUSSION

Although most participating clinics expected higher rates, almost everyone involved agreed that the assessment process was extremely valuable. The participating clinics and IAP staff in St. Paul believe completing an immunization assessment allowed them to:

- accurately assess immunization levels according to defined criteria that are consistently applied;

- establish baseline immunization rates;
- identify key areas for improving service delivery and vaccine coverage;
- identify missed opportunities for immunization;
- identify children with missing immunizations to allow for follow-up;
- assess the quality of record-keeping and documentation of immunization information;
- monitor changes in immunization coverage levels as successive assessments are completed;⁶ and
- assess the effectiveness of current tracking and follow-up systems as well as the need for systems changes.

Clinics interested in obtaining CASA and/or the "Key Steps" guide can call Acute Disease Prevention Services at MDH, 612/623-5237. Both are available to all immunization providers at no cost. Local public health agencies can also provide information about immunization assessment on the community level.

Routine measurement of clinic immunization levels and practices is an important component of successful immunization programs. Succinctly stated, "What gets measured gets done."

MM

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and administered by Saint Paul Public Health.

Margo Roddy is a senior epidemiologist in the Acute Disease Prevention Services Section at the Minnesota Department of Health. She is responsible for CASA promotion and training for the state of Minnesota. Teresa Asper Anderson is an epidemiologist who coordinates the Saint Paul Immunization Action Plan at Saint Paul Public Health.

REFERENCES

1. Orenstein WA. Crossing the divide from vaccine technology to vaccine delivery. *JAMA* 1994;272:1138-9.
2. Centers for Disease Control and Prevention. Recommendations of the Advisory Committee on Immunization Practices: programmatic strategies to increase vaccination rates—assessment and feedback of provider-based vaccination coverage information. *MMWR* 1996;45:219-20.
3. Ad Hoc Working Group for the Development of Standards for Pediatric Immunization Practices. Standards for pediatric immunization practices. *JAMA* 1993;269:1817-22.
4. Bushnell C. The ABC's of practice-based immunization assessments. In: Proceedings of the 28th National Immunization Conference: 1994 June 13-17; Charlotte, North Carolina. Atlanta: Centers for Disease Control and Prevention, 1994:207.
5. Bushnell C. Provider-based assessment tools. Reported at the plenary session of the 30th National Immunization Conference (sponsored by Centers for Disease Control and Prevention): 1996 April 9-12; Washington, D.C.
6. Minnesota Department of Health. Clinic immunization assessment protocol. Minneapolis: Minnesota Department of Health, 16 November 1995:1-5.

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People and Places Making Medical News

People

Grant for Heart Failure Treatment

Jay N. Cohn, M.D., professor of medicine at the University of Minnesota Medical School, received a \$30,000 grant from Roche Laboratories to help establish the Heart Failure Society of America. The society will include health care practitioners, research scientists, and other professionals who research or treat heart failure, a condition that contributes to more than 250,000 deaths per year. It will serve as a forum for the exchange of information on the treatment of heart failure. In addition, the society will help set practice guidelines, monitor legislative activities, and shape health care policy decisions affecting the quality and cost of care for heart failure patients. Plans also call for publication of scientific papers and sponsorship of symposia and conferences.

Cohn is the founder of vasodilator therapy for the treatment of heart failure. The use of these drugs, which dilate the arteries, is now standard therapy and is considered one of the most important therapeutic advances in cardiology.

Hospice Preferred Choice Medical Director

Hospice Preferred Choice, Inc., has named Martha McCusker, M.D., medical director for the new hospice program. McCusker, an internal medicine physician with a specialty in geriatrics, is a faculty physician at the Hennepin County Medical Center. She is also an assistant professor of medicine at the University of Minnesota Medical School.

Hospice Preferred Choice, with a central office in Edina, will serve the 11-county metropolitan area, providing hospice care in private

residences and in long-term care facilities.

ASCRS President

David A. Rothenberger, M.D., of St. Paul, has been elected president of the American Society of Colon and Rectal Surgeons for 1996-97. Rothenberger is clinical professor and chief, Division of Colon and Rectal Surgery, Department of Surgery, University of Minnesota Hospital and Clinic in Minneapolis. He is also president and chief executive officer of Colon and Rectal Surgery Associates, Ltd., a 12-physician private practice based in Minneapolis and St. Paul, and a physician member of the board of directors for Medica Health Plans.

Harold S. Diehl Award

The Medical Alumni Society of the Minnesota Medical Foundation presented Severin Koop, M.D., with the Harold S. Diehl Award for his contributions to the welfare of society as a teacher of medical students, a leader of medical organizations, an educator, humanitarian, scientist, writer and philosopher, author of scholarly works, and for his contributions to the medical field. Koop, founder of the St. Cloud Ear, Nose and Throat Clinic, retired in 1993. In addition to his practice, he was a general medical officer for the U.S. Army from 1957 to 1959 and later served four months in the U.S. Army Reserve during Desert Storm. He was president of the Minnesota Medical Association from 1982 to 1983 and was a delegate to the American Medical Association House of Delegates for 11 years.

Places

St. Francis Medical Center Moves

The St. Francis Regional Medical Center, jointly owned by Allina

Health System of Minneapolis and Benedictine Health System of Duluth, has moved to a new Shakopee location called the South Valley Health Campus on County Road 17 and St. Francis Avenue, just south of the future Highway 169 Shakopee Bypass. The old hospital, located at 325 Fifth Avenue West in Shakopee, was founded by the Franciscan Sisters in 1938. The building has been sold to Scott County and will be removed to make way for new office space.

At 80,000 square feet, the new medical center is just over half the size of the old hospital. It has 39 private beds and expanded outpatient services. A cancer center and renal dialysis will be added to the center later this year.

The South Valley Health Campus also includes a Park Nicollet Clinic, a medical office building whose tenants will offer family practice and medical specialties, and a 51-bed transitional and long-term care facility operated by Health Dimensions Inc.

Socioeconomics

HealthEast Restructuring, Closing Two Hospitals

In a major restructuring, HealthEast is closing St. Joseph's Hospital in downtown St. Paul by the year 2000 and converting Midway Hospital into an outpatient and community care clinic next year.

HealthEast also is forming a partnership with Allina Health System and Children's Health Care to build an ambulatory health care campus on a 26.4 acre site at Lake Road and Interstate 494 in Woodbury. The groups chose the site for its accessibility and because of the projected long-term growth in the area. On the Woodbury campus,

HealthEast will develop a new HealthEast St. Joseph's Hospital consisting of 70 inpatient beds to open by the year 2000. By then, all services will be discontinued at the current St. Joseph's Hospital.

The cardiovascular and oncology services currently located at St. Joseph's Hospital downtown will be relocated to St. John's Hospital in Maplewood. HealthEast plans to expand St. John's to accommodate growing demand for outpatient services and medical office space.

The HealthEast Midway site will house outpatient, home-centered, physician, and educational services. HealthEast will work with the community to conduct a community health assessment to define other service needs. In addition, HealthEast plans to develop centers of innovation and design, computer technology, and corporate services on the campus. HealthEast officials expect that the hospital's conversion will involve workforce reduction or reassignment of about 400 full-time equivalent positions.

HealthEast President and Chief Executive Officer Tim Hanson said HealthEast's plans are based on an analysis of the East Metro area, which showed that by the year 2000, the East Metro will have 370 excess hospital beds. Although there are too many beds overall, too few are located in areas experiencing population growth.

HealthEast Developing Seniors' Care Campus

Also as part of HealthEast's restructuring plan, HealthEast Senior Care and Dakota County Housing and Redevelopment Authority are developing HealthEast River Heights Campus, a seniors' health care campus at the site of HealthEast's old Divine Redeemer Hospital in South St. Paul. The first phase of the project includes the renovation of the Divine Redeemer building and the adjacent professional building. The renovation is expected to be

completed by the end of this year.

HealthEast Bethesda Lutheran Care Center, a nursing home located at the downtown St. Paul Bethesda facility, will relocate to the new campus (the nearby Bethesda Hospital and Rehabilitation Center will not be affected).

The new facility will include 117 licensed beds for both custodial and convalescent care. It will also have a 33-bed dementia care unit for residents with dementia; a unit for providing subacute services, including intravenous therapy, respiratory care, wound care, and other complex nursing care; and a unit to serve the needs of long-term care residents.

Space in the renovated professional building will be rented to businesses that focus on services and conveniences for seniors and other populations. In addition, the Dakota County Housing and Redevelopment Authority plans to build an independent living facility that will have 34 one-bedroom and 20 two-bedroom apartments for persons age 55 and over.

'U' Regents Approve Sale of Hospital to Fairview

The University of Minnesota Regents approved a detailed proposal to merge University Hospital with Fairview Health System (see "Fairview, University Hospital Hammering Out Merger Details" in last month's *Minnesota Medicine*, page 50). The University Hospital and Fairview Riverside Medical Center, across the Mississippi River from one another, will become one campus known as Fairview University Medical Center. Fairview will pay \$87.5 million for university assets, including the hospital building and parking ramp.

The regents approved the merger with a 9-1 vote; two regents were absent. The regents gave university administrators authority to negotiate a final contract (by September 30) and implement the merger. The organizations must still determine the fate of about 3,000 University Hospital employ-

ees, including how many will transfer to Fairview and how their pay and benefits will change. The groups must also appoint a governing board, on which the university will hold a majority of seats, and reorganize the 430 members of the university's practices from 18 separate group practices into a single organization (see below). Completion of the University Hospital/Fairview merger is planned for January 3, 1997.

University of Minnesota Medical School Faculty to Unite

The faculty of the University of Minnesota Medical School has voted to create a single, multi-specialty group practice to replace the 18 individual practice plans providing medical services at the university and other Twin Cities hospitals. The new practice, a nonprofit foundation faculty practice organization (FPO), is expected to begin operations in January 1997.

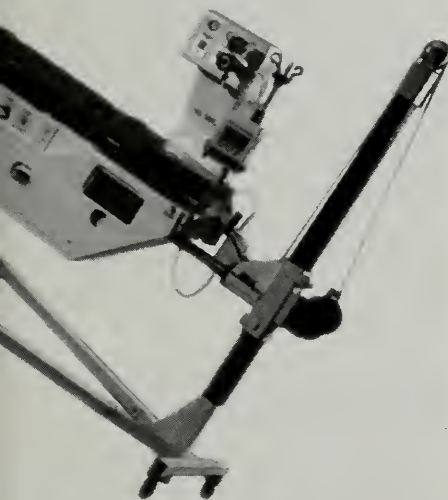
The new FPO, to be named at a later date, will include more than 430 physicians representing all medical specialties. It will be one of the largest and most comprehensive medical groups in the region. The FPO will remain a distinct entity affiliated with the medical school, with most clinical care being delivered at the new Fairview University Medical Center.

HealthPartners Ending Some Referrals to Riverside

HealthPartners will start sending some of its patients to Methodist Hospital instead of Fairview Riverside effective January 1997. Mary Brainerd, executive vice president at HealthPartners, said the decision is not related to Fairview's merger with University Hospital; it is based on market research on patient preferences, hospital performance factors, quality and outcome results, and input from medical staff and board members. She said that Methodist is more convenient for most patients.

continued

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HealthPartners will continue to refer patients to Riverside for obstetrical, neonatal, mental health, and chemical dependency treatment; about half of HealthPartners admissions at Riverside are in those areas, said Pam Tibbetts, Riverside's administrator.

HealthPartners patients accounted for 39 percent of Riverside's 28,000 inpatient admissions and 25 percent of its \$173.5 million in net patient revenue last year.

'U' Transfers Ownership of Methodist-Affiliated Residency Program

The University of Minnesota and HealthSystem Minnesota have agreed to transfer ownership and administration of the Methodist Hospital/University of Minnesota Family Practice Residency Program from the university to HealthSystem Minnesota, which owns Methodist Hospital and Park Nicollet Clinic.

The university retains responsibility for the program's accreditation and academic affiliation. Ken Kephart, M.D., of Creekside Family Physicians continues as the program director. The program will become a component of the Institute for Research and Education HealthSystem Minnesota, formerly known as the Park Nicollet Medical Foundation.

Affiliated with Methodist Hospital for more than 20 years, the residency program provides three years of training to 18 medical residents specializing in family practice. Residents spend part of their time in the classroom and part learning patient care in a clinic setting at Creekside.

'U' Joins HealthPartners for Medical Training

The University of Minnesota Academic Health Center has entered into a five-year educational affiliation with HealthPartners Institute for Medical Education to collaborate in training resident physicians, fellows, and other health care professionals. Under the agreement, HealthPartners physicians and pharmacists (who are also university faculty) will train university medical and pharmacy students and residents at St. Paul-Ramsey Medical Center and other HealthPartners sites. The arrangement also lays the groundwork for expanding clinical training to other health care professions.

Employers' Health Care Costs Have Stabilized

The cost of providing health care coverage to employees has come under control in the past five years but remains a concern, according to a recent U.S. Department of Labor study. Employers' health insurance costs rose by only 0.1 percent in the 12-month period ending June 1996, compared with an average of almost 15 percent a year in the late 1980s, according to the federal Employment Cost Index.

While the growth in health care costs has, indeed, dropped off, many employers also have shifted to less expensive managed care plans and have required employees to pay a larger portion of premiums. In addition, fewer employees are covered by their employers.

The Labor Department survey found that enrollment in fee-for-service plans dropped from 95 percent in 1984 to 50 percent in 1993. The average cost per employee is about 19 percent less under managed care as compared with traditional indemnity plans, according to Foster Higgins, a benefits consulting firm.

The study also found that for organizations with 100 or more employees, 54 percent of workers contributed to premiums for family coverage in 1983 compared with 76 percent in 1993. The portion of premiums that employees pay has also increased, from about 15 percent in the late 1980s to more than 30 percent in 1995.

Fewer employees are covered, some because they cannot afford their share of the premiums, but others because they are covered under their spouses' plans. The portion of full-time employees participating in employer-sponsored health care at companies with 100 or more employees dropped from 96 percent in 1983 to 82 percent in 1993, according to the study.

Blue Cross Gives \$30,000 to Rural Health Care Initiative

The Blue Cross and Blue Shield of Minnesota Foundation has contributed \$30,000 to the Northeast Minnesota Primary Care Fund to help communities in northeastern Minnesota recruit and retain health care providers. The fund provides financial assistance to students and medical residents of primary care professions who agree to practice in northeastern Minnesota upon completion of their training. The fund is administered by the Minnesota Center for Rural Health, a Duluth-based nonprofit organization. Qualified candidates include

primary care physicians, nurse practitioners, and physician assistants.

"Based on our discussions with key providers in our region, it is clear that health care provider recruitment is a major concern," said Terri Beckmann, BCBSM vice president for northeastern Minnesota. Part of the grant will be used immediately to sponsor providers interested in the program and part used later to finance additional new providers for the area in future years.

UCare Minnesota Signs with QHA and MRHC

UCare Minnesota, a St. Paul-based HMO, has signed agreements with both Quality Health Alliance (QHA), a south-central Minnesota health care provider cooperative, and MN Rural Health Cooperative (MRHC), based in southwestern Minnesota, to provide coverage to enrollees of government health programs.

Through the programs, prepaid consumers of MinnesotaCare will have access to the cooperatives' full-service networks of physicians, hospitals, and allied health professionals. The Minnesota Legislature had required that all MinnesotaCare participants enroll in a managed care program by mid-August. Services under each agreement began September 1.

UCare Minnesota, developed in 1984 by the Department of Family Practice and Community Health at the University of Minnesota Medical School, was created specifically to serve low-income Medicaid and General Assistance recipients. It is the fourth largest HMO in the state, with more than 48,000 members.

Counties included in the agreement with QHA are Blue Earth, Brown, Faribault, Le Sueur, Martin, Nicollet, Sibley, Waseca, and Watonwan. The counties served through the agreement with MRHC are Big Stone, Chippewa, Kandiyohi, Lac Qui Parle, Lincoln, Lyon, Renville, Redwood, Swift, and Yellow Medicine.

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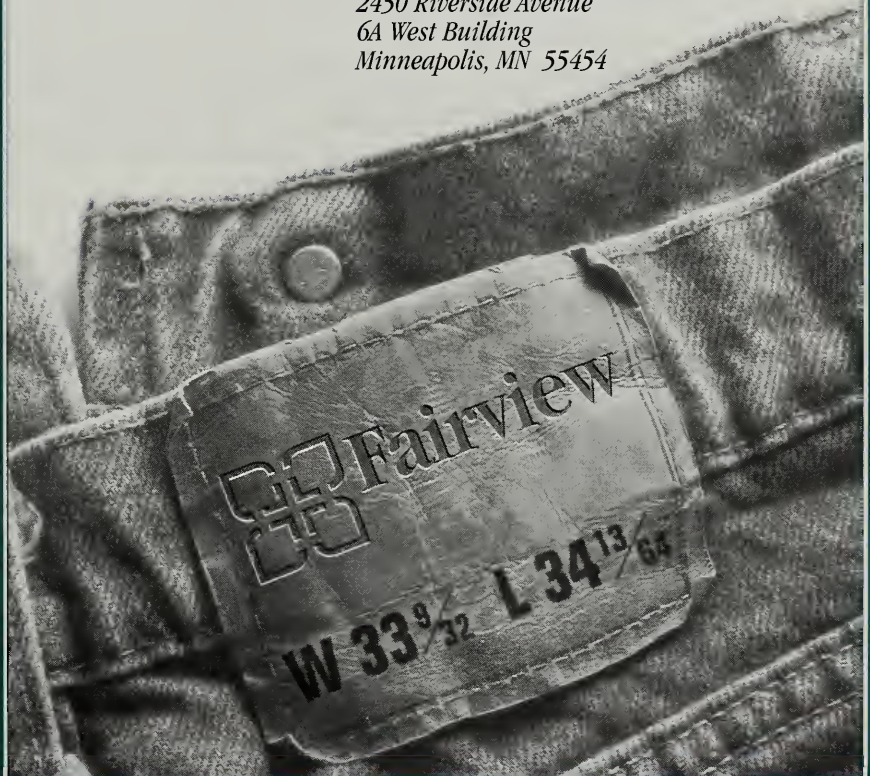
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Ramsey Clinic and HealthPartners Physician Groups Join

Ramsey Clinic and HealthPartners (formerly Group Health) physicians have joined forces to create the HealthPartners Medical

Group. The 525-member physician group is second only to Mayo Clinic in size.

Terry W. Crowson, M.D., and Paul Brat, M.D., leaders of Ramsey Clinic and HealthPartners Staff

Physicians, respectively, will be co-medical directors of the new group. They have named the following as associate medical directors: Macaran Baird, M.D., associate medical director, primary care; Brian Rank, M.D., associate medical director, medical specialties; J. Daniel Nelson, M.D., associate medical director, surgical specialties; and Daniel R. Hanson, Ph.D., M.D., associate medical director, behavioral medicine.

National Rural Health Center Opening in Duluth

The federal Office of Rural Health Policy and the rural health offices of each state have provided \$20,000 to start a national clearinghouse based in Duluth, Minnesota, to help rural communities deal with managed care and other health issues. The center, called the National Rural Community Health Resource Center, will open this fall at the Minnesota Center for Rural Health in the Fitger's Brewery Complex. It will be co-directed by Terry Hill, who also is director of the Minnesota Center for Rural Health, and Susan Kaye, administrator of the North Woods Community Health Center in Minong.

Medica Choice Rated Best of Five Plans in State

Medica Choice, part of Allina Health System, was rated the highest of five Minnesota health plans in a national survey of plan members conducted by the Center for the Study of Services, based in Washington, D.C. The other plans were Group Health and MedCenters, both part of HealthPartners; Blue Plus, offered by Blue Cross and Blue Shield of Minnesota; and Allina's Medica Primary.

The survey asked at least 245 members of each plan about more than 20 aspects of care and compared the results with national averages. The categories included access to care, health advice by phone, ease of getting appointments, communication skills of

doctors, and choice of physicians.

Medica Choice and Group Health were rated higher than national averages in overall quality. MedCenters finished closer to the average. Blue Plus and Medica Primary ranked slightly below the national average overall.

The results of the survey, which included 72,000 members of about 300 health plans, are published in "Consumers' Guide to Health Plans." It can be ordered by calling 800/213-7283.

Law & Policy

Court Halts Medicare Payments to Christian Science Health Providers

Medicare and Medicaid payments to Christian Science health care practitioners violate the separation of church and state and are unconstitutional, decided U.S. District Judge Richard Kyle in St. Paul last month. The decision could mean a loss of \$7 million to \$10 million in payments to Christian Science health practitioners if the decision stands on appeal.

The church has received Medicare and Medicaid reimbursements under provisions in the law since 1965. Kyle said the special federal accommodation given to the Christian Science church "smacks of religious favoritism."

The church, based in Boston, teaches that prayer can cure illness and injury. Church practitioners do not use drugs or other conventional medical treatments. The lawsuit was led by Iowan Rita Swan, whose 16-month-old son died in 1977 of meningitis after receiving only prayer treatment. Swan now heads the organization Children's Healthcare is a Legal Duty.

"Congress should not be giving public money to unlicensed, untrained providers whose services are designated to promote a particular church theology," said Swan as quoted in the *St. Paul Pioneer Press*. "To us, it's not so

much the waste of taxpayers' money. ... The endangerment of children ... is what motivated us."

When ill, some members of the church go to Christian Science sanitariums or nursing homes, where all employees are members of the religion. Patients must undergo prayer treatments from church-certified spiritual healers. The church's nurses are not state-licensed, nor are they supervised by any state-licensed personnel.

Church officials say the Medicare and Medicaid payments pay for general medical care, such as bandages, bedpans, and comfort—not for prayer. "If we pay for Medicare taxes—and we have ever since 1965—it isn't reasonable that our way of relying on healing shouldn't be reimbursed to the same extent others are," said church spokesperson Norman Bleichman.

BCBSM Given Go-Ahead in Tobacco Lawsuit

A Minnesota Supreme Court decision in July allows Blue Cross and Blue Shield of Minnesota to pursue its lawsuit against the tobacco industry. The health insurance company is a co-plaintiff with the state of Minnesota. The court granted Blue Cross authority to pursue its claims of consumer fraud, antitrust, unlawful and deceptive trade practices, and false advertising, but ruled that it cannot pursue a tort, or breach of duty, claim against the tobacco industry because it is too far removed from the relationship between smoker and manufacturer.

The tobacco industry had argued that Blue Cross did not have a right to be part of the lawsuit, maintaining that Blue Cross was not injured by smoking-related health costs because it passed those costs along to customers as higher premiums. The court ruled unanimously (with two justices abstaining) that Blue Cross has the necessary interest to pursue the claims it decided to allow.

Medical Research

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Umbilical Blood Shows New Promise for Transplants

Umbilical cord blood is a safer source of stem cells than bone marrow and also may be a treatment alternative for adults in need of bone marrow transplants, according to a University of Minnesota study published in the August 1 issue of *Blood*. The researchers found that umbilical cord blood contains enough cells to use the treatment on larger patients; currently cord-blood transplants are used almost exclusively for children.

The researchers followed 13 unrelated umbilical cord blood transplant recipients at the university and five at Children's Hospital in Orange County, California. The survival rate after six months was 65 percent, and only one patient developed serious graft-versus-host disease. With bone marrow transplant, the risk of developing the life-threatening complication is 30 percent to 40 percent. The researchers also found no correlation between the number of stem cells infused and recovery, suggesting that the treatment would be successful in larger adult patients.

John Wagner, M.D., associate director of the university's bone-marrow transplant program, said a study is needed to compare cord blood transplants directly with bone marrow transplants. He is working with the National Institutes of Health to set up a multicenter study.

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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

S E P T E M B E R 1 9 9 6

Sept. 4-7 **Eighth International Workshop on Malignant Hyperthermia** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Sept. 9-10 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Sept. 11-15 **Radiology '96: Neuroradiology, Musculoskeletal Radiology Mammography** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

E N D U R I N G M A T E R I A L S

Oct. 25 **Infectious Disease Update** Institute for Research and Education HealthSystem Minnesota; Park Nicollet Clinic, St. Louis Park, MN. CONTACT: Kari Haeger, Park Nicollet Clinic, 3800 Park Nicollet Blvd., St. Louis Park, MN 55416; 612/993-3527.

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

Videotapes: **Emerging Infectious Diseases** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 12-14 **Practical Surgical Pathology Conference in Honor of Louis H. Weiland, M.D.** Mayo Medical Laboratories; Mayo Clinic, Rochester, MN. CONTACT: Kathy Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, Rochester, MN 55905; 800/533-1710.

Sept. 16-17 **Managing Care for People with Serious Mental Illness** Minnesota Medical Association and the Medical Policy Commission of the Minnesota Department of Human Services; Minneapolis Airport Marriott, Bloomington, MN. CONTACT: Bonnie Martin, DHS, 444 Lafayette Road, St. Paul, MN 55155; 612/282-5883.

Sept. 18 **Endorectal Ultrasonography: A Hands-on Experience** University of Minnesota—Continuing Medical Education; Midway Hospital, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Sept. 18 **Molecular Biology of Colorectal Cancer** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Sept. 19-20 **Mayo Clinic Update in Hepatology and Liver Transplantation** Mayo Foundation; Hotel Sofitel, Minneapolis, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 19-20 **Sixth Annual Practical Pediatrics Course for the Primary Care Physician** Children's Health Care; Children's Health Care—St. Paul, MN. CONTACT: Betsy Julius, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/813-6206.

Sept. 19-21 **Echocardiography for the Sonographer 1996: Focus on Myocardial and Valvular Disease** Mayo Clinic; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 19-21 **Principles of Colon and Rectal Surgery/59th Course** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Sept. 20-21 **Gas Exchange and Pulmonary Function** University of Minnesota—Continuing Medical Education; San Francisco, CA. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Sept. 21 **Current Concepts in Glaucoma** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Sept. 21 **Blending Complementary and Traditional Medicine for Quality Care** HealthEast St. John's Hospital; Holiday Inn North, Arden Hills, MN. CONTACT: Annette Anderson, 1700 University Avenue West, St. Paul, MN 55104; 612/232-5104.

Sept. 22-25 **Radiology Refresher Course** University of Minnesota-CME; Silverado Country Club, Napa, CA. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Sept. 24-27 **Annual Community Mental Health Conference** Minnesota Medical Association and Minnesota Association of Community Mental Health Programs, Inc.; Maden's Conference Center, Brainerd, MN. CONTACT: Cory Bryan, 1821 University Avenue West, Suite 350-S, St. Paul, MN 55104; 612/642-1903.

Sept. 26-27 **Twenty-third Mayo Clinic Pediatric Days** Mayo Clinic; Radisson Plaza Hotel, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 26-28 **Twenty-first Annual Fall CME** Minnesota Academy of Physician Assistants; St. James Hotel, Red Wing, MN. CONTACT: Cindy Ulshafer, 1825 Center Street, Centerville, MN 55038-9779; 612/653-4736.

Sept. 26-29 **Mechanical Ventilation: Principles and Applications** University of Minnesota-Continuing Medical Education; Radisson Hotel, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Sept. 29-Oct. 4 **Advances in Diagnostic Radiology and Advanced Radiology Life Support** Mayo Foundation; The Broadmoor Resort, Colorado Springs, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

O C T O B E R 1 9 9 6

Oct. 2-4 **Internal Medicine Review** University of Minnesota-Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 3-5 **Mayo Vascular Symposium 1996: Advances and Controversies in the Multidisciplinary Management of Vascular Disease** Mayo Clinic and North American Chapter of the International Union of Angiology; Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

Oct. 4 **Insights and Outlooks '96** St. Paul Heart Clinic; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440; 612/992-3826.

Oct. 6-11 **Laboratory Diagnosis of Fungal Infections** Mayo Medical Laboratories; Portland Marriott at Sable Oaks, South Portland, ME. CONTACT: Kathy Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Oct. 11 **Northwestern Pediatric Society 84th Annual Meeting** University of Minnesota-Continuing Medical Education; Sheraton Inn Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 11 **Ophthalmic Plastics Course** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 11-12 **Advanced Life Support in Obstetrics** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 11-12 **Nursing Home Medical Directors** University of Minnesota-Continuing Medical Education; Sheraton Inn Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Physician Cancer Support Group

A year ago, a peer support group for physicians with cancer was formed by the Hennepin Medical Society at the Virginia Piper Cancer Institute. Regular monthly meetings started in August to provide a setting in which physicians could exchange concern and feelings on the challenges unique to those in their profession with cancer. About 25 physicians and spouses have attended one or more session. There is no charge for the group.

The group meets:

Second Thursday of each month
7 pm to 8 pm
Virginia Piper Cancer Institute
800 East 28th Street at Chicago Avenue
Minneapolis, Minnesota

If you have any questions about the group, contact Dick Sellers, facilitator, at 612/863-4000.

Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., September 15 for November ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Family Practice, Ob/Gyn to join progressive 14-physician group practice. Rural college town 30 miles from St. Paul, Minnesota. New clinic and new hospital. Contact Robert B. Johnson, M.D., River Falls, WI 54022; 715/425-6701. (*2/96-R)

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: oncology/hematology, family practice, general internal medicine, neurology, and general surgery. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary \$80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Olmsted Medical Center is seeking BC/BE physicians in the following specialties: emergency medicine and family medicine. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. Positions currently open include emergency room and family medicine departments in Rochester and branch office locations. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes nine branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (5/96-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: internal medicine (oncology, pulmonology, and nephrology), family practice, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (8/96-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Physician Needed to work part time in multidisciplinary clinic. All calls confidential to doctor's private line, 612/889-5973. (6/96-R)

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Stamping Out Disease

Like that ursine ranger, Smokey, medicine and society have popularized prevention as the best means for fighting disease while saving money. To the cries of,



"So much disease, so little money," preventionists have replied, "Put out the fire before it starts. Blowing out matches is easier and cheaper than fighting forest fires." But what appeared obvious for years is now being questioned. Does prevention save lives, money, both, or neither? This month's *Minnesota Medicine* examines one

facet of secondary prevention, screening, and considers whether we should all don ranger hats.

Why isn't screening farther along in 1996? Comparisons, costs, convenience, and cognition have hampered the progress of screening.

Comparisons: Previous models of prevention, like sanitation's control of infectious disease, immunization's conquest of smallpox and polio, and Pap smears' reduction of invasive cervical cancer, have shaped our expectations of future gains from preventive and screening programs. As a prototype screening tool, Pap smears are cheap, catch cervical cancer at a pre-invasive, treatable stage, and reduce morbidity and mortality in the screened population. This success shouts at us, "Catch it early, and you can cure it!" However, as Peter Benson, M.D., notes in his editorial (page 12), not all screening tests have such clear results. Statistical snares like lead-time bias, described by Steven Jacobsen, M.D., Ph.D. (page 23), muddy the waters.

Costs: As with most debates in medicine, the greenback lurks barely below the surface of the screening discussion. Money explains reluctant Medicare and insurance coverage of proven screening tests like Pap smears and mammograms. Money explains

the current coding game these same organizations play that force physicians to guess the rules for what diagnostic codes will trigger payment for screening.

The question, "Is it worth it?" is reasonable for any medical intervention. Increasingly, respected voices like those of economists Henry Aaron and William Schwartz question the value of small returns from screening large populations. They suggest that saving lives now through screening may cost the system more later, when the same patients return needing treatment for different diseases.

Convenience: As our Chisago Health Services profile shows (page 8), convenience has been a barrier to screening in clinics. Prevention counseling takes time and staff. Effective screening takes recall and notification systems. Explaining screening to patients and overcoming biases nurtured by faulty media portrayal or by the power of the Pap smear comparison take time. A recently developed three-minute explanation of the PSA test shows that short, convincing education can be done in the clinic, but it all adds minutes to time-starved days.

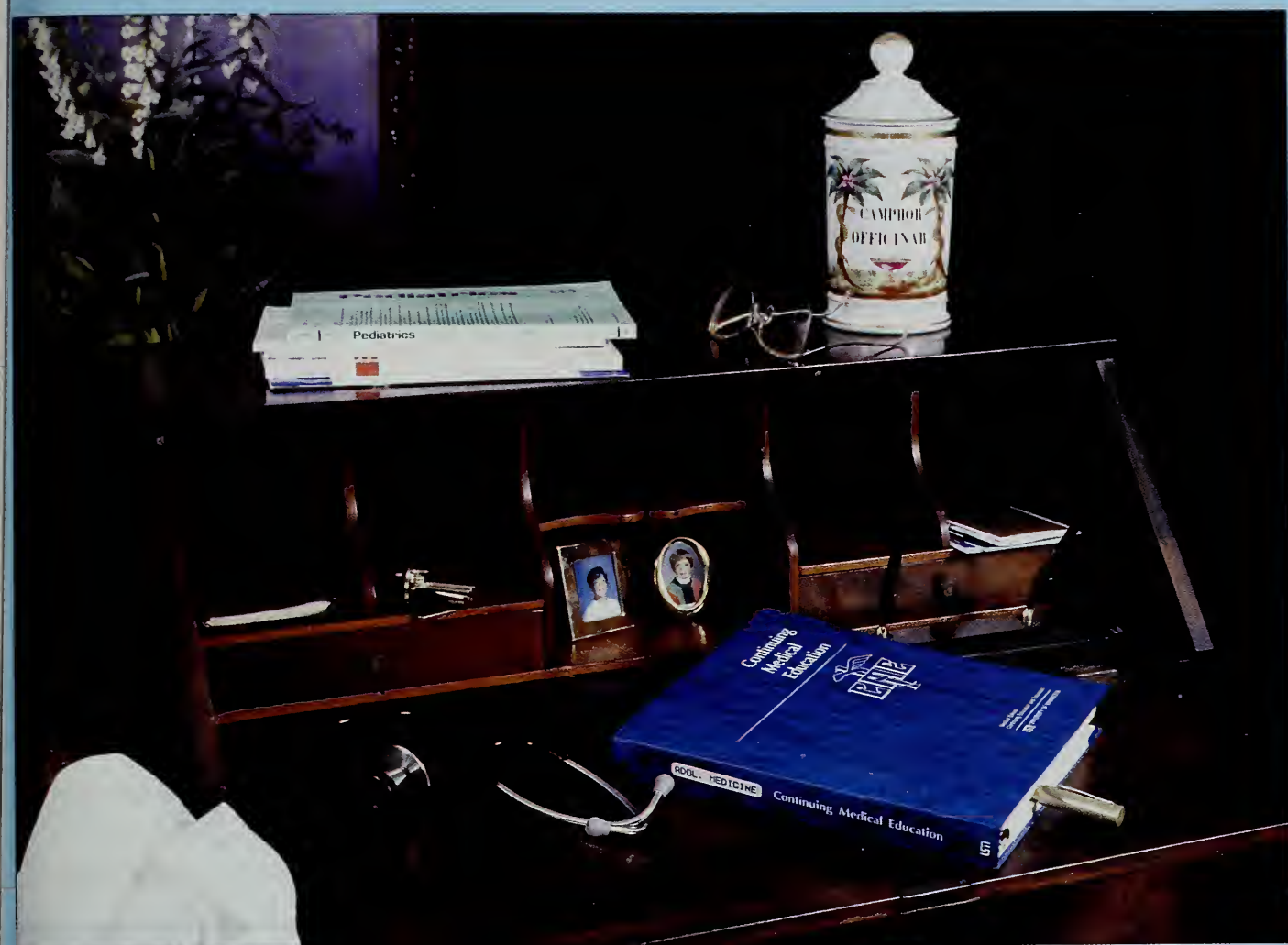
Cognition: The most perplexing questions about screening involve human behavior and thought, factors explored in Miriam Feldman's feature story on the repercussions of genetic screening (page 14). A recent book, "Psychosocial Effects of Screening for Disease Prevention and Detection," edited by Robert Croyle, also explores the cognitive obstacles to prevention. If we find risky behavior, can we change it? Do smokers stop smoking? Do hypercholesterolemics stop eating ice cream? If not, why screen? If we label people with a disease or risk factor, do we produce anxiety that stimulates healthy behavior, or do we just produce anxiety?

We're facing a long walk ahead in confusing woods. We need to decide whether it's better to find and snub the smoldering match or let forest fires burn—a big question for us average bears. Meanwhile, society needs to decide what it really wants from medicine and at what price.

—Charles Meyer, M.D., Editor-in-Chief

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"As with most debates in medicine, the greenback lurks barely below the surface of the screening discussion."

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Bone Density Scans

Evidence to Support Widespread Use Not Strong—Yet

So many tests, so little time. The American attitude toward health care can seem like a sad parody of the Barnes and Noble T-shirt referring to books. More tests chasing more health. If you have the test, why don't you use it? That's the core question in the PSA controversy. It's the heart of the coronary angiogram debate. And it's the accusatory point of a *Star Tribune* article from last fall¹ on bone density scans and osteoporosis.

The main headline reads: "Test scans for early signs of an age-old nemesis." A subhead reads: "A test that measures and compares bone density is a useful but not often used tool to help women at risk fight osteoporosis." The main article accurately documents the frequency of osteoporosis in women. It confirms that bone-density scans can detect early osteoporosis. It bemoans their underutilization. It contends that doctors have ignored the risk of osteoporosis because they believe it is "only" a disease of old women, fear that it is untreatable, or just think it is "boring." Also given as a reason doctors have neglected osteoporosis is their alleged belief that bone-density testing is too expensive. The article concludes with a statement from "osteoporosis expert" Dr. Allan Frankel that bone-density scans are like mammograms 15 to 18 years ago, when everybody but doctors realized their value.

It is hard to determine the usefulness of any new test in medicine, especially expensive ones (as most new tests inevitably are). The utility of a given test in a given clinical situation takes multiple studies and

many years. And utility does not just mean finding disease; it means guiding treatment in a beneficial, cost-effective way. It means having a treatment to offer that will affect the course of the disease diagnosed.

Let's examine three tests in different stages of development: Pap smears, mammograms, and the genetic test for Huntington disease. For years, Pap smears have won the cost-effectiveness Oscar. Cheap and relatively reproducible, they find a potentially fatal disease at an early, curable stage.

The role of mammograms has been clarified recently after undergoing the 15-year trial described by Frankel. Multiple studies showing reduced mortality with routine screening and decreased cost of the test now prove mammograms to be an effective preventive medicine tool.

Unlike these veteran tests, the genetic test for Huntington disease is fresh out of the blocks. Currently, it is expensive and investigative. But even if it becomes cheaper and more available, it raises a fundamental dilemma about tests and disease finding. We can diagnose a person's likelihood of developing Huntington disease, but, once diagnosed, we can't do anything about it. Whether it is useful for the person to know becomes not a clinical or therapeutic issue, but a personal, moral, and psychological debate (see related feature story, page 14).

Bone-density tests sit somewhere between mammograms and the Huntington test. They clearly can find a disease at an earlier stage than routine x-rays and before clinical symptoms appear. They are more

expensive than mammograms and less expensive than the Huntington test. They are readily available. So why aren't we using them more often? The answer lies not in age or sex bias or the power wielded by the insurance industry, but, rather, in what has been available to treat osteoporosis.

Estrogen clearly slows the development of osteoporosis in postmenopausal women. The evidence for Vitamin D and calcium supplementation is contradictory. Calcitonin, Didronel, and the newly released Fosamax[®] show promise in already-established osteoporosis. But we do not have the proof implied in the newspaper article that starting medications at the first sign of bone loss (as detected by bone densitometry) prevents osteoporosis later in life. Is it worth the cost for 20 to 40 years of medication, not to mention the possible drug side effects, to prevent an unknown number of women from developing compression fractures?

Contrary to the sense of the newspaper article, we don't have that answer—yet. Should we wait for the evidence before we rush thousands of women to their local McBone densitometry units? I think we should. Misguided coverage of scientific issues like this one risks creating a conventional wisdom that certain tests are so crucial that future randomized studies are almost unethical. This headlong hurdle to promote technology without scientific support is fueled by participation of interested parties, like the Bone Measurement Institute, a non-profit, wholly owned subsidiary of

Merck & Co. Inc., which, coincidentally, makes Fosamax®.

Medicine has tough choices ahead of it. The balancing act between cost and effectiveness will get even more difficult. When we get good scientific support for what we do, we need help from the media in communicating that to the public. When we don't have enough evidence to support widespread use of tests or treatments, we need the press to convey that, too.

MM

"Media Watch" is an occasional column written by Minnesota Medicine's editor-in-chief, Charles R. Meyer, M.D., an internist with Consultants-Internal Medicine in Minneapolis.

REFERENCE

1. Roan S. Test scans for early signs of an age-old nemesis. Star Tribune 1995 October 19; Sect. E3.

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A POUND of CURE

Physicians today recognize the importance of preventive health care—and for good reason. Statistics show that quitting smoking reduces the risk of heart disease and lung cancer, that identifying anomalous cervical cells before they become cancerous can save a life, that lowering blood pressure can reduce the risk of stroke. By delaying or altogether preventing some illnesses, such care can also save thousands of dollars in future health care costs. Yet, despite widespread agreement about preventive health benefits, many patients have yet to receive these services routinely.

Why is providing preventive care so difficult? Is there some way to deliver preventive care to the majority of primary clinic patients?

The results of the Twin Cities greater metro area IMPROVE Project (Improving Prevention Through Organization, Vision and Empowerment) point toward a solution. Funded by a four-year, \$3.5 million grant from the U.S. Agency for Health Care Policy and Research and jointly sponsored by Blue Plus and HealthPartners, IMPROVE began a randomized controlled trial in mid-1993. Forty-four primary care clinics affiliated with the HMOs agreed to participate; 22 clinics began working with IMPROVE's continuous quality improvement (CQI)-based process to develop a better system for providing preventive services; the remaining 22 clinics acted as the study control group.

While it's commonly acknowledged that U.S. medicine emphasizes cure rather than prevention and that third-party payers reimburse for procedures, not advice and education, lack of reimbursement has by no means been the only barrier to routine preventive care.

"Doctors are often overwhelmingly busy just responding to the primary complaints and requests of our patients," explains Nancy Alexis, M.D., a family practice physician and the IMPROVE team leader at Chisago Health Services (CHS), a three-clinic system in Chisago City, Minnesota. "In addition, except for people coming in for routine checkups, there simply aren't any spontaneous reminders or requirements to deal with any aspect of prevention, even if there is time for it. And unlike many other aspects of medical practice, few clinics have any type of organized approach to providing preventive services."

IMPROVE staff believe an organized approach is the key to better preventive care. "These services haven't been consistently delivered because we have focused on their *content* to the exclusion of the *delivery process*," explains Leif Solberg, M.D., principal investigator for IMPROVE. "IMPROVE's goal is to address the main barriers to delivery of preventive services by helping a team at each clinic use the techniques of CQI to develop an organizationwide system for providing these services, one that fits each setting's needs," says Solberg, also a family physician and clinical director of research at HealthPartners.

After agreeing to focus on eight preventive services (see the sidebar, page 60), each of the clinics first created an interdisciplinary team responsible for developing a system to provide the services. "Right from the beginning, IMPROVE staff gave

*By eliminating
barriers to rou-
tine preventive
services, Chisago
Health Services
has found new
ways to improve
patient care.*

BY JOSEPH M. MORIARITY

us a lot of help," says Alexis. "Training meetings helped our team—which includes doctors, nurses, medical assistants, and staff representatives from each of our three clinics—learn effective ways to approach, analyze, and solve problems, and how to work better together. A manual developed by IMPROVE staff included many examples of approaches other clinics found effective."

The CHS team found that preventive services weren't routinely offered to patients, says Alexis. Mechanisms for identifying patients for these services were applied sporadically, and use of established care delivery guidelines was inconsistent. "What's more, patient notification of test results was causing confusion and lack of follow-up," she says.

To solve these problems, the CHS team developed a procedure to ensure that screening questions are asked routinely, and also developed a uniform documentation system that everyone can understand and use easily—one that shows at a glance the status of each patient. Although IMPROVE staff gave the CHS team much help, what they didn't do was give them a blueprint to follow; instead, the team followed a CQI process and developed an approach appropriate for each CHS clinic. "We did all the work, but the support given by IMPROVE staff made the endeavor seem possible," says Alexis.

To save physicians time, the CHS team relies on nurses, certified medical assistants, and nurse practitioners to go through the screening checklist with patients and to help with teaching. "But the physician's word still carries much weight with patients," says Alexis, "so physicians, too, have to emphasize the importance of preventive care and encourage their patients to spend time following

through on recommendations."

While IMPROVE staff have only begun collecting post-study data, CHS' own informal survey results are encouraging. "We found improvement at all three clinic sites," says Terry Martinson, M.D., CHS medical director. "Our satellite clinics were best at collecting information and telling patients about screenings. Finding why we're having poorer results at our main clinic is one of our next tasks. Nevertheless, compared with where we started, we are definitely doing better."

These results have put to rest the initial skepticism of some CHS physicians who questioned whether IMPROVE could really make a difference. "Some, of course, were hesitant at first," says Martinson. "We all guard our time jealously. In general, however, our physicians and nurse practitioners have had a long-standing interest in preventive health. At the time we were contacted by the IMPROVE Project, we were already looking at developing clinical guidelines for preventive care, and with the support and structure for making changes promised by IMPROVE staff, it was a perfect opportunity for us."

How have patients responded to this new prevention program? "Though IMPROVE's evaluation data aren't complete, my patients' comments indicate that we're clearly increasing awareness," Martinson says.

Alexis has heard many reports, especially from the certified medical assistants who do the initial screenings, that patients feel staff are taking more interest in them and their overall health. "They have the sense that we care about more than just their initial complaint," she says, "and that we are trying to help them stay healthy—and they appreciate this."

continued on page 60



PHOTOGRAPH BY BRUCE BAIRD

*Some of the CHS staff working with the IMPROVE Project:
Back (left to right): Nancy Alexis, M.D., and Linda Myer, R.N.;
Front: Becky Johnson, C.M.A., and Tanya Ostlund, C.M.A.*



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Daniel R. Hanson, Ph.D., M.D.

*Associate Medical Director,
Behavioral Medicine*

Dr. Hanson is an assistant professor in the Department of Psychiatry at the University of Minnesota and an adjunct professor in the University's Department of Psychology. He previously served as chair of Ramsey's Department of Psychiatry.



Terry W. Crowson, M.D.

*Co-Medical Director,
HealthPartners Medical Group*

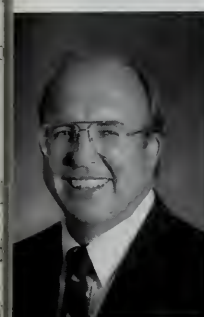
Dr. Crowson will also provide senior leadership for the group and oversee its clinical, operational and financial performance. In addition, Dr. Crowson will continue to serve as president of Ramsey Foundation.



Richard Heinrich, M.D.

*Assistant Medical Director,
Behavioral Medicine*

Dr. Heinrich will also provide leadership for the group's Behavioral Medicine Division. He has served as chair of the HealthPartners Mental Health Department since 1991.



Macaran Baird, M.D., M.S.

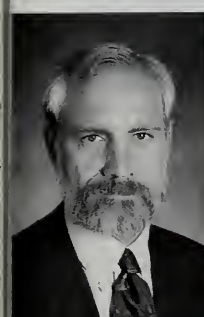
Associate Medical Director, Primary Care
Dr. Baird joined HealthPartners in 1995 and has a distinguished career in family medicine, including serving as chair of the Department of Family Medicine at the State University of New York Medical School at Syracuse.



Barry Baines, M.D.

*Associate Medical Director,
Centralized Patient Care Services*

Dr. Baines heads the departments of After Hours Care and Continuing Care which include urgent care clinics, home care, geriatric, hospice, social work, and volunteer programs. Dr. Baines is also a deputy medical director for St. Paul-Ramsey Medical Center.



Brian Rank, M.D.

Associate Medical Director, Medical Specialties

Dr. Rank brings a wealth of experience to the group, including more than 10 years at Hennepin County Medical Center. There he held many posts, including director of the Residency Teaching Program, director of the Hematology/Oncology Program and director of the Autologous Bone Marrow Transplant Unit.



Thomas Knabel, M.D.

*Associate Medical Director,
Quality and Utilization Management*

Dr. Knabel manages clinical practice improvement to ensure the most appropriate use of referral and hospital resources. He also directs the integration of medical guidelines and outcome studies in clinic operations.



J. Daniel Nelson, M.D.

*Associate Medical Director,
Surgical Specialties*

Dr. Nelson has served as chief of Ophthalmology at St. Paul-Ramsey Medical Center and is an expert in diseases of the cornea. He has also served as director of Ramsey Foundation and Ramsey Clinic.



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Limitations of Screening

Why Population-based Screening Doesn't Always Work

By Peter Benson, M.D.

Our sense of logic tells us that early detection of disease, especially cancer, should improve outcomes and increase the possibility of cure. Through public health campaigns and media coverage, the benefits of screening have become well-known to the American public. Interested patients who have heard about PSA, CA-125, and other new screening markers may want to know more about these tests and may wonder whether they, or their loved ones, should be screened.

When considering screening options for patients, we as physicians and public health advocates should ask ourselves several important questions. What evidence do we have that a particular screening test (however successful in a statistical sense) will actually improve the health and quality of life of an individual patient or of the populace overall? If improvement can be demonstrated, does it come at an acceptable cost in this era of limited health care dollars? And finally, if we recommend screening, what are the possible adverse outcomes, and what is the likelihood of a false-positive diagnosis? As obvious as the benefits from such interventions may appear, history reveals the difficulty in realizing those benefits. At least among laboratory tests, two significant and interrelated technical limitations frequently foil the cost-effectiveness and efficacy of screening efforts, especially when applied to unselected "healthy" individuals.

The Normal Range Problem

Selecting a normal range for most laboratory tests is traditionally done by taking the middle 95 percent of all values obtained from a "normal" population.

While this method is simple and well accepted, by definition it will label 5 percent of this group as abnormal, even in the absence of disease. If this normal range is used in screening a large population, a relatively constant percentage of healthy patients will have abnormal results (false positives) along with the subjects who actually have disease (true positives). Although the number of false positives will be proportionately small when compared with the total number screened, it may be large when compared with the number of true positives.

This problem of false positives generated by the normal range is compounded when multiple analytes are measured. Since only 95 percent of patients with a normal result on one test will also have a



ILLUSTRATION BY MASSIMO ZETTI

normal result on the second test, only 90 percent (0.95 times 0.95) of all patients will have a normal result on both. With three tests, the proportion drops to 86 percent. By the time 14 tests are performed, the chance of an entirely normal test panel in a disease-free patient drops below 50 percent. Many of these false-positive results will be borderline, but in many cases, borderline results reflect the early disease we are trying to find.

This explains why multitest blood chemistry panels have never worked well for general screening. When sequential multichannel chemistry analyzers were introduced in the 1960s, many physicians and institutions believed that inexpensive, multi-analyte test panels had the potential to reduce costs and improve patient health. For many physicians, the SMA-12 or 20 became part of the routine checkup, and healthy patients were reassured that their "blood work" looked fine. Physicians who practiced at the beginning of this era may recall the many asymptomatic parathyroid adenomas that were incidentally discovered because of an elevated serum calcium, but evidence of overall benefit to patients from these screening test panels remains lacking. Today, most authorities believe that only a handful of these automated chemistry tests (such as cholesterol, glucose, and creatinine) have any potential for effective disease detection among the general population,¹ and the American College of Physicians and the U.S. Preventive Services Task Force currently do not recommend multitest biochemical screening panels.²

Rarity of Disease in Unselected Populations

The limitations of screening tests are amplified when these tests are applied to unselected populations. This is because the predictive value of a screening test strongly depends on the prevalence of the disease in the group screened. As mentioned above, a more or less constant proportion of false positives will be expected from virtually any laboratory test, depending on the "normal" cut-off selected. If the prevalence of disease in the tested population is relatively high, then the number of true positives detected will exceed false positives, and the predictive value of a positive test will be high. Conversely, if the same test is applied to a population with low disease prevalence, false positives may exceed true positives, and the predictive value of the test will shrink.

The performance of any test can be improved by preselecting the patients (based on family history,

demographics, or other risk factors) to increase the prevalence of disease in the tested group. (However, since most individual diseases are rare in the general population, unless a screening test has exquisite specificity, true positives are often lost in a sea of false positives.)

An important example of this is the use of CA-125 in screening for ovarian cancer. This tumor marker is increased in the majority of women with non-mucinous ovarian carcinoma, but elevations may also result from ovarian cysts, endometriosis, and a variety of other benign conditions. Still, the observed specificity of CA-125 has exceeded 97 percent for screening of postmenopausal women in some studies.³ Unfortunately, with an absolute prevalence of ovarian carcinoma in this group of approximately one in 1,000, there are 30 false-positive results for every true positive identified. Although ultrasound studies can help reduce this number, a significant proportion (perhaps 10 percent) of women with positive results will eventually require laparotomy for definitive diagnosis. Of these women, fewer than half will have ovarian carcinoma, and half of these will have surgically incurable disease. The majority of women undergoing surgery as a result of screening will have benign conditions for which laparotomy was arguably unnecessary.

While ovarian carcinoma will take the life of more than 14,000 American women this year, the poor screening performance of CA-125 is rightly daunting to physicians trained under the time-honored dictum *primum non nocere*. Attempts have been made to improve the specificity of this test to acceptable levels by looking for coordinate elevation of several tumor markers,⁴ but this approach suffers the limitations of multitest screening described earlier. Would patients and physicians be comfortable deciding to forgo further investigation because only one of three tumor markers is elevated? Studies of CA-125 for ovarian cancer screening continue, but a recent NIH consensus conference⁵ concluded that no evidence exists to show CA-125 can be effectively used in widespread screening for ovarian carcinoma or that such screening would result in decreased, rather than increased, morbidity and mortality.

The Past, Present, and Future

While skepticism regarding the usefulness of popu-

LIMITATIONS continued on page 59



ILLUSTRATION BY ALAN MAZZETTI

GENETIC SCREENING: NOT JUST ANOTHER BLOOD TEST

Genetic testing can tell us more than we've ever known about our probable destiny, but the results can be more confusing than helpful.

BY MIRIAM K. FELDMAN

When Sally Spaulding was 28 years old she learned that her father had Huntington disease, giving her a 50-50 risk of carrying the gene for the dominant genetic disorder. Six years later, in 1989, a predictive genetic marker test indicated that her risk was 92 percent. To get that more precise information, Spaulding spent four months collecting blood samples from numerous family members—her parents, her sister and brother, her father's sister and husband, their child and grandchildren—some of whom she hadn't spoken with in 20 years.

Finally, in 1994, a breakthrough in testing allowed Spaulding to stop playing the odds game. On the basis of a simple blood test, she learned what she already had long suspected—that she does, indeed, carry the gene for the degenerative neurological disorder. Knowing helps her prepare for the future, she wrote in a poignant essay published in the April 3, 1995, *Newsweek*. The Minneapolis woman elaborated in a recent phone interview. "When the test became available, I knew I wanted it. I'm the kind of person who wants to err on the side of being conservative."

But what exactly does Spaulding know? She knows she will at some point develop Huntington disease, a condition for which there is no cure. For Spaulding, knowing has spurred her to think more seriously about financial security, and it has allowed her to put uncertainty to rest. "It changes how you live your life day-to-day. [I'm] trying to make the most out of every day right now," she says.

In most cases, however, genetic tests do little more than

confirm that a person does or does not have a chromosome with a molecule that's out of whack. For example, women who test for the BRCA1 or BRCA2 genes, which predispose them to ovarian and breast cancer, know only whether they have an impaired chromosome; they don't know their destiny. Most genetic tests, whether for cancer or other genetic conditions, are like that—they offer nothing more than a probable risk assessment, much like the early test Spaulding took for Huntington disease. Diagnostic tests exist for only a handful of cancers and an equally small number of genetic conditions, such as Huntington disease.

The public is ready for these tests, though. And that troubles genetic experts who understand testing's limitations and fear more and more patients will be asking their doctors for that cancer test they just read about in *Glamour* or the test for cystic fibrosis they heard about on TV. And unless physicians understand testing's ramifications, they may be willing to comply.

Welcome to the still-blurry intersection of medicine and genetics—where scientists can tell us more than we've ever known about our probable destiny, but where medicine can do very little with that knowledge. Experts emphasize the need to proceed cautiously in a world uncertain about how genetic information will affect a patient's job security, insurance coverage, and psyche.

As Spaulding's case illustrates, genetic testing, once a daunting process involving multiple family members, has become as easy as sticking out your arm and drawing 30 ml of blood. Or has it?

FEW BLACK-AND-WHITE ANSWERS

"I can't tell you how many patients come in here and say, 'I want that gene test for breast cancer,'" says Cate Walsh Vockley, M.S., a certified genetic counselor in the Department of Medical Genetics at Mayo Clinic. "They think it's a simple blood test. They think it's very black and white. It's not."

Genetic information is complex, often difficult to interpret, and can be overwhelming, Walsh Vockley explains. Even patients who have been adequately counseled and informed before testing don't always take the news well, she says. "A lot of people go in and think they'll be fine. They find out they're likely to carry a gene and are devastated. They're not prepared to deal with it."

"I can't believe how powerful genetic information is," says Mary Ahrens, M.S., a genetic counselor in the University of Minnesota's Division of Medicine and Genetics and the Familial Cancer Clinic. It's different

from medical information. As she puts it, something can be done for the patient with high cholesterol. "But you can't change your genes. Genetic conditions never go away. If you have a genetic condition, no matter what, you have to live with it. That can be very hard for people to accept."

Walsh Vockley, who works primarily with familial cancer patients, explains that most tests only offer a risk assessment. Except for a few diagnostic genetic tests, most fall into a gray area where the results can be more confusing than helpful. And problems can arise if patients don't understand the difference between risk and certainty. "You might find an uninterpretable piece of information about the family," she says. "Or the results may be, 'We can't tell you anything more than what you know now.' If we find an ambiguous result, or no result, people say, 'I must be OK,' when in fact, this means, 'We can't tell you anything.' Physicians and patients alike don't understand that."

Joanne Hilden, M.D., is a pediatric oncologist with a particular interest in the RET gene mutation, which is 100 percent predictive for the ultimate development of medullary thyroid cancer. The RET gene test is the only one Hilden will run because, as she puts it, "I believe I know what it means."

What's more, something can be done with the information; if a mutation is detected, a prophylactic thyroidectomy can be performed.

But if all a patient can obtain is a probable risk assessment, Hilden will argue strongly against testing, unless it is done within the context of long-term research. "If we can't tell [a patient] what the meaning is, why on earth would we have them tested outside of the research arena?" she asks.

Hilden, who is affiliated with Children's Health Care—St. Paul, fears patients won't be getting that kind of advice, though. "People aren't getting that on the airwaves," she says.



"They're getting told that cancer testing is available." But the testing isn't that simple. "You don't just say, 'Stick out your arm; I'll let you know.'"

Genetic screening takes time. Spaulding, for example, underwent a neurological exam, as well as extensive psychological testing and evaluation.

Follow-up counseling sessions ensued once she learned the results. That time-intensive routine, which was established for the Huntington gene, has been generally replicated in other areas of genetic testing.

Trine Shimota, M.S., a genetic counselor who does prenatal genetic counseling, spends at least an

THE RIGHT TO KNOW—WHAT?

BY MIRIAM K. FELDMAN

My mother called the other morning. She asked about the kids and the snow. She hated to say it, but the weather in Tucson was delicious. Then she got to the point: "Have you thought about having your ovaries removed?"

This is the woman who calls to remind me to eat broccoli because she believes it possesses anti-carcinogenic powers. She used to nag me to stand up straight. That was before she had bigger things on her mind, before my sister was diagnosed with ovarian cancer last year, at age 41.

My mother is convinced that the women in our family are ticking time bombs. She may be right. More than 30 years ago, her sister died of ovarian cancer. Two women in our family could be coincidence, but it's something to take note of, particularly for a disease that doctors say is rare.

Still, I tend to live my life as if I'm not a bomb about to go off. For the most part, my days are consumed by my children, husband, friends, work, the dog. But I confess to sometimes wondering whether the twinges I feel down below are part of the normal ebb and flow of things, or some sign that I, too, have the Big C.

They're fleeting thoughts, though, for I'd drive myself crazy if all I did was sit around waiting to explode.

In fact, the morning my mother called, I'd been clearing the last of the breakfast dishes, thinking about an article that was due, and wondering whether my family would tolerate pizza two nights in a row. I had not been thinking about my ovaries.

"What's to think about?" she asked. "Just have them out. It's simple. Snip. Snip."

Simple for her. She doesn't know I once cried

when the dentist was about to pull a tooth, and I have 32 of them.

On the other hand, I'm through having children, and it's just a matter of years until I'm in menopause. Why not get rid of my ovaries? But then I'd have to ask the same about my breasts.

If we're looking at odds, my risk of developing breast cancer is greater than my risk of developing ovarian cancer. I'd hate to lose my breasts. Not if I don't have to. After all, this disease may not run in the family. We may be experiencing some statistical fluke.

It so happens, there's a way of knowing whether I'm programmed to self-destruct. Last year, scientists discovered that as many as 1 percent of Jewish women of Eastern and Central European descent carry a mutated form of a gene, known as BRCA1, that predisposes them to breast and ovarian cancer.

If these women also come from a high-risk family, one in which there is a history of the disease, their odds of developing breast and ovarian cancer go off the charts.

The question is, do I want to know if I possess this mutated gene? Admittedly, if I were to be tested and found to have it, I'd have a more compelling reason to heed my mother's advice. But I'm not sure that even a test result would be reason enough for me to begin deleting body parts.

So I called Kathy Faber-Langendoen, an oncologist at the University of Minnesota and a faculty associate at the university's Center for Biomedical Ethics, for an informed perspective. She said, "Diagnosing a messed-up gene is not the same as diagnosing a disease." In other words, even if I have the gene, I might not have or even get the disease.

hour with patients who are considering amniocentesis. "I can't see any physician doing that," she says. "It's very time-consuming." Shimota, who works at both Maternal Fetal Medicine and United Center for Breast Care at United Hospital in St. Paul, always starts with a complete family history, a routine part of

any genetic counseling procedure. Then she talks to patients about the risks and limitations of testing. She also explains what a test can and cannot tell and discusses chromosomes and chromosomal abnormalities.

Shimota fears that in the absence of such extensive counseling, patients are likely to make too many

Complicating this discussion is the fact that scientists have decided to withhold the test for the mutated BRCA1 gene to the public, on the grounds that there are too many unsettled questions about the risk posed by the gene and what might be done to lessen that risk.

"A woman has a right to know," I fumed upon hearing that.

Faber-Langendoen agreed that scientists can come off sounding paternalistic, treating women as if they can't handle the information. "On the other hand," she said, "the question about a woman's right to know prompts the question, 'The right to know what?'"

While she doesn't say that women shouldn't be tested, Faber-Langendoen asserts that a genetic test doesn't settle every question, and even raises new ones. "What you know when you get the test back is that you have a chromosome that has this molecule that's out of order," she said. "You don't know what your destiny is."

What's more, others tend to find out the results, particularly insurers, and our society has no protection in place for that eventuality. Women who choose to be tested need to be counseled about all of these matters, she said.

Even if nobody else were to know, the bottom line is, I would. But what, as Faber-Langendoen suggested, would I really know? And what would I do with that information?

For starters, I could decide to be more aggressively screened, which in my case means regular mammograms for breast cancer and a CA125 blood test and pelvic sonogram for ovarian cancer. I'm already doing that.

I could even, I suppose, do nothing and just live with the knowledge that I have a messed-up gene; given my family history, I'm already living under a cloud.

I keep thinking about my sister's friend Ken, who has lived with HIV for nearly 10 years. "I can go out and be hit by a truck in the next five minutes," he said, when I asked him how he keeps on going.

The point is, we all live with some risk. We all have screwed-up genes, as Faber-Langendoen said. And any one of us can get hit by a truck. So for now, I'll forgo the test, just as I'll ignore my mother's advice.

Snip. Snip.

Like the author of a *New York Times* article who ultimately decided against genetic testing for a different disorder, I, too, want to retain "the privilege of hope." And, like Ken, I accept that life is full of risks. There are no guarantees. I could prophylactically remove my breasts and ovaries and wham!, when I'm least expecting it, something else could get me.

That's not to say I won't be vigilant. I'll look both ways when I cross the street. And I'll talk to my daughter about the need to pay attention to her body, the need to be screened, for this affliction hangs over her head, too.

She's only 16. Perhaps when she's my age, she'll choose to be tested. By then, there may be a point to it all.

As my sister said, "Probably when Jessie's 40, they'll have all these things they can do."

I hope so.

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wrong assumptions. "A lot of people think this [test] will tell whether or not their baby's going to be perfect." But the situation is more complex than that, and without a proper family history, which might indicate the need for more extensive testing, patients might not get the information they need to make a proper decision.

The importance of such extensive education and counseling was underscored by Arno G. Motulsky, M.D., who chaired a committee of the Institute of Medicine of the National Academy of Sciences that recommended ways to avoid involuntary and ineffective genetic testing. Motulsky's committee, which delivered its report two years ago, called for expanded

WHEN A PATIENT WANTS TO BE TESTED

What would you do? That's one question Trine Shimota, M.S., never answers, though patients do ask. "I turn it back to the patient," says Shimota, a genetic counselor in the Department of Maternal Fetal Medicine at United Hospital and at the United Center for Breast Care. Genetic counselors favor a nondirective approach, Shimota explains. "You try not to use your own values and background in your counseling. You always try to give all the information so patients can make up their own minds."

There's probably not a genetic counselor who would disagree. Testing for a genetic disorder, they say, is a strictly personal decision, albeit an exceedingly complex one because of its ramifications for individuals, as well as their families. "The decision to test or not to test needs to be patient-driven and not physician-driven," insists Cate Walsh Vockley, M.S., a certified genetic counselor in the Department of Medical Genetics, Mayo Clinic.

This could be a hard concept for physicians to grasp because it challenges ordinary assumptions about how doctors and patients interact. In a typical medical encounter, the patient says to the doctor, "If you were me, what would you do?" says Mary Ahrens, M.S., a genetic counselor in the University of Minnesota's Division of Medicine and Genetics and the Familial Cancer Clinic. "Our response is, 'This is your situation, your family, and it's ulti-

mately your decision to make.' This usually blows them away."

Why? Because, says Ahrens, "it's different from the traditional medical model, where most people say, 'I am sick. I need to feel better. What can I do?' The doctor says, 'You need to do A, B, and C.'" In that interaction, the patient has entered into a nonverbal contract with the physician in which he or she agrees to follow the doctor's orders, says Ahrens. "When patients go in for genetic counseling, it's a different approach."

Walsh Vockley agrees. "Physicians make recommendations to patients all the time. 'You should have this surgery, or else.' Or, 'You should have this medication.'" Genetics is different, she explains, because it involves making decisions that can affect other family members.

But even in cases where a patient wants testing in order to make a highly personal decision—for example, whether to undergo prophylactic treatment such as a mastectomy—the approach must remain nondirective. "For a physician to say, 'Here's what you should do,' is not fair," Walsh Vockley says. "We're not coming from the same perspective as the patient."

That's why education is paramount, according to these experts. "Whatever works for the patient once they've been well educated," says Walsh Vockley, "is probably what's right for the patient." —MKF



genetics education in medical school curricula and for bolstered genetics education for the general public and health practitioners.

"Most genetic tests are not like any other blood tests," says Motulsky, a professor of medicine and genetics at the University of Washington, Seattle. "They should be ordered only after fully informing the patient about their impact on the individual and the family."

Interestingly, once patients are fully informed, they often decide against testing. Ahrens says that fewer than a third of the individuals who make an initial phone call to the Familial Cancer Clinic actually follow through with a visit. "Genetic information is very scary to them," she says.

Many of the patients Walsh Vockley counsels also decide against testing, suggesting that with enough information, patients reach the same conclusion as the experts: A genetic test is not just another blood test, and the results are rarely black and white. "I do have some people being tested for certain conditions," Walsh Vockley says, "but if it's a test that's not likely to provide a specific answer, people are being realistic. It's going to cost a lot of money, and the yield is low in terms of learning something."

COST, CONFIDENTIALITY

Genetic testing is expensive. For example, OncorMed, a genetic testing lab in Gaithersburg, Maryland, charges between \$420 and \$1,175, depending on the gene being sequenced. That charge is exclusive of physician office visits and the genetic and psychological counseling that accompany genetic testing.

Such costs can be a deterrent, notes Walsh Vockley, who works with many self-insured individuals, including farmers and small business owners. She says patients are afraid to call their insurance companies, fearing they'll lose their coverage. And in this computer age, even patients who don't intend to make a claim worry that their condition or predisposition will be discovered.

Steps are being taken to remedy this problem. Minnesota, for example, has a law that went into effect last January prohibiting insurance companies from discriminating on the basis of prediagnostic test results. But the law is a beginning, at best, since it excludes self-insured plans and offers no protection once the disease is manifest.

The potential for insurance discrimination was highlighted in an August *Oncology* article, which told the story of a woman who tested positive for the

BRCA1 gene at the University of Pennsylvania. Upon request, her insurance carrier agreed to pay for an elective prophylactic mastectomy. However, when surgeons found cancer cells in one of the woman's breasts, the insurer denied payment, arguing the cancer was a preexisting condition.

A related concern is whether genetic information should become part of the medical record. Walsh Vockley cites Huntington disease—for which there is a test, but no cure—as an example of why the issue is hotly debated. On one side are those who fear that documenting test results in the medical record could lead to discrimination. On the other side are those who argue that the results could, at some point, offer significant clinical information.

A BRAVE NEW WORLD FOR PHYSICIANS

Time will tell how genetic testing is handled in the future. Scott Hickman, a services representative for OncorMed, the company that has developed tests for melanoma, breast cancer, and colon cancer, envisions the day when genetic testing will be routinely handled in the doctor's office. While testing kits may not be on drugstore shelves next to, say, home pregnancy kits, Hickman says, "Hopefully, we'll get to the point where the patient comes in and it's one of the standard tests that is done."

Naturally, OncorMed, which promotes itself to physicians through attractive brochures, has an economic interest in seeing that day come sooner rather than later. For now, though, the company runs only 75 to 100 tests a month, most of them submitted by genetic counselors at major medical centers or by oncologists. Currently, OncorMed refuses to run a test without an extensive family history, counseling, medical verification, and patient consent forms. Such rigorous safeguards are not required of testing companies, but they are generally supported by the scientific community.

Richard King, M.D., associate director of clinical research for the Institute of Human Genetics at the University of Minnesota, agrees that genetic testing will someday become routine in physicians' offices. "I'm not totally against that," he says. "Rather than try to limit it to specialty clinics, it would be better to train all physicians to deal with it."

King, who is also a professor of medicine and pediatrics at the university, envisions changes in medical school curricula so that future physicians will know how to do pretesting evaluation, to interpret genetic tests, and to do appropriate follow-up, includ-

ing prevention and screening. But training alone won't be enough if physicians aren't given the time to practice what they learn.

"I'm worried that this can't be done in managed care because of the time constraints," King says. Physicians will have to educate health care systems that genetic testing cannot be done in a 15-minute clinic visit, he says.

If physicians aren't given the time and the training, King fears some patients will be tested without adequate counseling and will make poor decisions based on limited or incorrect information. "Ultimately, what's going to happen is a woman will go in and be told in a 15- to 30-minute session that she carries this gene. Her interpretation is she'll get breast cancer, and she'll have a prophylactic mastectomy. Many women could have organs removed unnecessarily."

For now, while genetic testing is so new, it is still appropriate for physicians to refer patients to specialists and genetic counselors, King says. But as the field advances, the system will be overwhelmed. Currently, most testing is limited to cancer, he explains, but he foresees it expanding to include cardiovascular, pulmonary, and other common diseases. "At that time, [genetic testing] will be well beyond the scope of geneticists and genetic counselors and will be in the purview of the primary physician," he says.

The university's Ahrens thinks physicians should be referring patients to genetic experts, but she also

acknowledges the Catch-22 nature of the situation. "The problem is, I don't know if there are enough genetic counselors. Physicians will have to take more responsibility for learning about genetic information and for giving it to the patient." Otherwise, patients and the medical system may be overwhelmed with so much new genetic information, she says.

As Walsh Vockley puts it: "We need to talk about what happens in the brave new world when all of this stuff is bombarding us, when there aren't enough genetic counselors to handle the load." The genetics community will support physicians, and many major medical centers are in the process of developing educational programs directed at community-based physicians, so physicians should not feel they are on their own, she says. "They're not alone."

The support is there, and physicians may have to learn to use it. "Ten years from now," predicts King, "the testing is going to be pretty routine. Physicians or physician assistants will be trained to deal with this kind of information. It's not going to be done by geneticists or genetic counselors. There's not enough of them, nor does there have to be. That's a bit of a maverick view, but also a realistic view, and from someone who also practices internal medicine. The trick is training physicians."

MM

Miriam Feldman is a free-lance writer in Minneapolis and a frequent contributor to Minnesota Medicine.



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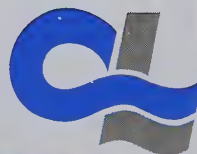
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Screening Practices

Do They Work? Should They Be Done?

To counsel patients appropriately, physicians need to understand the validity of scientific evidence supporting screening.

Steven J. Jacobsen, M.D., Ph.D.

Editor's Note: In this month's first Public Health Report, Dr. Steve Jacobsen presents a framework to help physicians decide which screening tests are appropriate and which diseases are appropriate targets for screening. We can't screen every person for every disease, but it isn't appropriate to just screen those patients who request it or those who can afford it. Instead, it is best to determine which tests have proven benefits, which have no proven benefits, and which haven't been assessed. It is then possible to tailor screening programs to fit individual patients' needs while balancing the risks and potential benefits.

—Barbara P. Yawn, M.D., M.Sc.,
Series Editor

In medical practice today, preventive services are a part of everyday care. Physicians not only treat patients to cure existing disease, but they also help patients live with their conditions and help prevent or delay the detrimental effects of their diseases (tertiary prevention). In addition, physicians prescribe measures to prevent the occurrence of disease (primary prevention) and to detect disease early in its natural history, presumably at a time when interventions can cure (secondary prevention).

Secondary prevention is usually targeted at two patients. When directed at patients who have sought care for some unrelated problem, these efforts are labeled "case-finding." When applied to the general population through mass efforts, these secondary preventive efforts are called "screening." In either situation, the goal of secondary prevention is to identify previously undiagnosed disease in individuals on the basis of a test, examination, or other procedure.

At face value, screening has great intuitive appeal. When disease is detected early, it may be possible to alter its natural history. For example, detecting cancer before it has invaded surrounding tissue or before it has had a chance to differentiate may provide the opportunity to excise or eradicate the tumor before it becomes life-threatening.

Screening can also be used to target persons for tertiary prevention. For instance, if phenylketonuria is detected early in a child's life, dietary restrictions can prevent the developmental sequelae of this condition.

Unfortunately, although screening can benefit patients, the potential side effects may actually cause harm. For example, individuals labeled hypertensive tend to develop different sets of illness behaviors, including increased absenteeism and restriction of common living activities. Individuals who screen positive for certain diseases are at risk of adverse effects from further diagnostic tests or therapies. Each test or treatment may produce anxiety and impinge on the patient's quality of life.

Because of the potential benefits and risks associated with screening, it is important for physicians to have a clear understanding of how screening tests are assessed. The media and many professional organizations have dramatically increased public awareness of screening practices, and patients are demanding these procedures. The duty of private, state, and federal insurance carriers to provide coverage for these procedures has been debated openly across the country, further bolstering awareness. Thus, today more than ever, physicians must be able to understand the scientific evidence supporting a particular screening intervention and be able to counsel their patients accordingly.

Following is a review of the basic tenets of screening and the types of evidence that are used to evaluate the efficacy and effectiveness of screening maneuvers.

EVALUATING A SCREENING TEST'S MERITS

Several characteristics should be considered in evaluating the merits of a screening test: 1) Can it work? (efficacy); 2) Does it work? (effectiveness); and 3) Should it be done (is it sufficiently important in terms of public health to warrant the effort)?

CAN IT WORK?

After determining that a screening procedure does lead to early detection, its impact on clinical outcomes, such

as survival, must be assessed. At first blush, survival seems an easy outcome to assess. However, apparent increased survival may be deceptive because of lead-time and length biases.

Lead-time bias results from a shift of some portion of the time that a person has the disease but has not been diagnosed to the time the individual is diagnosed with the disease. The bias occurs because the disease is detected earlier in its natural history. Survival time *following disease diagnosis* will be increased, even if interventions do not prolong life. Without therapeutic benefits, however, survival time would not increase *following the biologic onset of disease*.

Length bias occurs when a new screening tool is introduced and the age, stage, and other characteristics of individuals receiving new diagnoses shifts. If the test is detecting the disease earlier in its natural history, then newly diagnosed patients should be younger and at earlier stages of disease. The test will likely detect disease in some patients who otherwise would not have been diagnosed for many years because of a more indolent natural history. Screening will identify proportionately more of these individuals, causing survival time from diagnosis to appear improved.

DOES IT WORK?

Although it is important to consider whether a screening intervention can lead to prolonged survival, a number of factors may affect whether the screening works in the community at large. People may not want to be screened if, for example, the procedure is painful or otherwise invasive. Also, physician beliefs communicated to the patient can affect compliance. Anxiety, denial, or forgetfulness can cause patients to avoid or miss screening

tests. Screening is less effective if patients are unwilling to undergo subsequent therapeutic maneuvers.

SHOULD IT BE DONE?

Whether a screening maneuver should be used depends on the burden of the illness in the population, the ability of the health care system to meet the increased demands of the screening program, and the balance between costs, risks, and benefits of the intervention. These considerations raise ethical, policy, and scientific questions.

Finite resources are available for health care. The allocation of resources to a screening procedure will reduce those available for some other procedure. When a large number of false positives leads to unnecessary diagnostic work (see related editorial, page 12), the screening test may lead to unacceptable monetary costs to society or psychological costs to the patient.

UNDERSTANDING THE LIMITATIONS OF VARIOUS STUDY DESIGNS

Ideally, a screening procedure should be thoroughly studied before it's introduced to the community at large. Once a screening technology becomes standard care, it is difficult to perform a randomized clinical trial because many people consider it unethical to allocate subjects to a control arm. Further, the number of subjects willing to be randomized in such a trial would probably be limited, and those who would enter such a trial may differ in compliance, background risk of disease, or burden of comorbid conditions from persons refusing to enter the trial.

When sparse or no data are available from randomized trials, observational data are often used to provide

SUGGESTED READINGS

1. Fletcher RH, Fletcher SW, Wagner EH. Prevention. In: Fletcher RH, Fletcher SW, Wagner EH, eds. *Clinical epidemiology: the essentials*. 3rd ed. Baltimore: Williams & Wilkins, 1996.
2. Sackett DL, Haynes RB, Guyatt GH, Tugwell P. Early diagnosis. In: Sackett DL, Haynes RB, Guyatt GH, Tugwell P. *Clinical epidemiology: a basic science for clinical medicine*. 2nd ed. Boston: Little, Brown and Company, 1991.
3. Hennekens CH, Buring JE. Screening. In: Hennekens CH, Buring JE, eds. *Epidemiology in medicine*. Boston: Little, Brown and Company, 1987.
4. Woolf SH, Battista RN, Anderson GM, Logan AG, Wang E. Assessing the clinical effectiveness of preventive measures: analytic principles and systematic methods in reviewing evidence and developing clinical practice recommendations. *J Clin Epidemiol* 1990;43:891-905.
5. McGinnis JM, Woolf SH. Background and objectives of the U.S. Preventive Health Services Task Force. *J Gen Int Med* 1990;5(suppl):S11-13.

information about the efficacy or effectiveness of a screening test. This information can be helpful, but there are limitations depending on the study design.

ECOLOGIC STUDIES

Ecologic studies use group-level data to compare outcomes in screened and unscreened populations. For example, in an ecologic comparison study, country-specific death rates for cervical cancer could be compared with country-specific utilization of Pap smears. If Pap smear screening is effective, countries with higher Pap smear utilization rates should have lower mortality rates for cervical cancer. Flaws in this design include confounding factors (prevalence of human papilloma virus in the case of cervical cancer) and the inability to tie screening directly to the individuals with lower cervical cancer mortality. Drawing such conclusions on the individual level from grouped data is called an ecologic fallacy. An ecologic trend study slightly improves this approach by, in this case, measuring cervical cancer mortality rates in a population before and after Pap smears were introduced. But even with an ecologic trend study, other secular changes could account for the changes in mortality rates.

CASE CONTROL STUDIES

The case control study is another observational study design that has been used to evaluate the efficacy or effectiveness of screening practices. Cases are defined as deaths caused by the disease or as persons with advanced disease. Controls are sampled from persons who do not have advanced disease or who did not die from the disease. Medical records of cases and controls are examined for the presence of screening behaviors. If screening is effective or efficacious, cases with advanced disease should have relatively fewer screening examinations than controls; if it is not effective, then there should be no difference in frequency of past screening practices between the two groups.

One problem with this study design is it's difficult to distinguish between examinations done for screening purposes, per se, and those done as part of a diagnostic workup. If diagnostic examinations are counted as screening, the findings will make the screening procedure look like it is a risk factor for developing advanced disease. Investigators have attempted to address this problem by excluding tests performed within a certain number of weeks or months prior to diagnosis.

Finding all screening histories, especially when a subject obtains care at multiple sites, can lead to systematic biases if more complete histories are found for certain types of cases.

COHORT STUDIES

The cohort study is one of the strongest observational study designs for determining the effectiveness of screening. In this design, the occurrence of advanced disease among an exposed group (screened) is compared with that of a comparison (nonscreened) group. If screening prevented advanced disease or death, then there should

be relatively fewer advanced cases among the screened cohort.

Although this study design may be less prone to some of the biases discussed above, self-selection is a potential problem. Persons who are at high risk for the screened disease or who are excessively worried may be more likely to enroll in screening studies, introducing systematic biases.

RANDOMIZED CONTROLLED TRIALS

Randomized controlled trials allow the investigator to randomly assign study subjects to screening or control arms. Randomization does not guarantee lack of systematic differences between treatment arms, but it does provide the best opportunity to control unknown and known confounding factors and limits the element of self-selection. Because analyses are generally made at the individual level, active follow-up can help sort diagnostic tests from case finding from screening. Although randomization may help assure that any observed difference can be attributed to the intervention, the results may not apply to other populations or settings.

CLINICAL IMPORTANCE

A rigorous evaluation of the scientific literature regarding a screening procedure is a large undertaking. There is no such thing as a perfect study, and the body of evidence needs to be considered in its entirety. It may be neither feasible nor ethical to conduct a clinical trial, making it necessary to base decisions solely on observational data (although one school of thought would discount any evidence from observational studies). Meanwhile, it is difficult for practicing physicians to systematically review every preventive procedure they might consider performing. A number of professional societies and government-sponsored agencies, such as the U.S. and Canadian preventive health services task forces, have formed panels to do this. Such panels often develop clinical practice guidelines or recommendations regarding the use of a specific practice.

For the practicing physician, these guidelines can be helpful in several ways. The structured approach and summary of the literature can help physicians educate their patients about the evidence for a given screening practice. As more and more patients wish to take part in the decisions regarding their own medical care, this information may help them reach a decision and may increase their compliance if they decide to undergo the test. These guidelines can also provide a framework for physicians to think about their own practices and determine whether deviations from the recommendations are appropriate.

MM

Steven Jacobsen is an associate professor and head of the Section of Clinical Epidemiology, Department of Health Sciences Research, Mayo Clinic and Foundation in Rochester, Minnesota.

Breast Cancer Screening in Minnesota

The Role of Physicians

Physician advocacy of mammograms and other breast cancer screening can help improve patients' compliance and reduce cancer-related morbidity and mortality.

Jane Ellen Korn, M.D., M.P.H., and Annette Bar-Cohen, M.A., M.P.H.

Editor's Note: October is Breast Cancer Awareness Month, and in this second Public Health Report, members of the Cancer Control Section of the Minnesota Department of Health provide an overview of breast cancer screening. The most frightening part of this discussion is the apparent "don't ask, don't tell" attitude patients and physicians have regarding mammography. The authors tell us that a key motivator for physicians to order mammograms is patient request, but many women are waiting for physician recommendations. The result: mammograms often aren't discussed. This "don't ask, don't tell" attitude has never worked in any area of medicine, and the report cards on mammography show that it doesn't work with mammography, either. Physicians should consider asking every woman over age 50 who has a life expectancy of more than two to three years whether she would like to have a mammogram.

—Barbara P. Yawn, M.D., M.Sc.
Series Editor

WHY BREAST CANCER SCREENING?

As the most prevalent cancer in women and the second leading cause of death from cancer in this population, breast cancer has emerged not only as a disease that touches the lives of many women, their families, and the physicians who treat them, but as a public health issue, as well. This year in Minnesota, 3,000 women will be diagnosed with breast cancer, and 730 women will die from it.¹ As with many other cancers, breast cancer survival improves with early detection—more than 95% of women with localized breast cancer survive at least five years, compared with 20% for those women with advanced disease at the time of diagnosis.²

Methods for early detection of breast cancer—mammography coupled with clinical breast examination—are among the few cancer screening tests currently available that can improve morbidity and mortality from cancer. Randomized controlled trials performed in the United States and Europe have shown that mammography every one to two years can reduce mortality by up to 35%.³ In fact, the drop in breast cancer mortality be-

tween 1989 and 1992 recently reported by the National Cancer Institute can be partially attributed to increased utilization of screening mammography over the last two decades.⁴

WHO SHOULD BE SCREENED?

In Minnesota, more than 75% of all breast cancer cases and 88% of all breast cancer deaths occur in women over age 50 (unpublished data, Minnesota Cancer Surveillance System). The older a woman gets, the greater her risk of developing breast cancer. Age-specific incidence data show that breast cancer incidence rates rise with age and that the increase continues upward through the eighth decade (see the figure). Although 5% to 10% of women are at significantly elevated risk of developing breast cancer because of genetic predisposition, advancing age is the most important risk factor for the vast majority of women.

Recently, a great deal of controversy has focused on guidelines for breast cancer screening. The benefits of mammography for women aged 50 to 69 are clearly supported by data from randomized controlled trials.³ For women aged 40 to 49, experts disagree in their interpretation of the data, and some national organizations have made recommendations neither for nor against screening mammography in this age group. Because of the small number of women studied in the 70 and older age group, many reported trials have had inconclusive results. However, it appears medically sound to screen women over age 70 who have a reasonable life expectancy, given the high incidence of breast cancer in this age group and the lack of evidence to suggest that mammography is any less accurate for women in their 70s than for women in their 50s and 60s.

WHICH SCREENING TESTS SHOULD BE ADVOCATED?

Breast cancer screening in the office should include mammography and clinical breast examination (CBE). Although the sensitivity of mammography approaches

90%, mammography cannot detect all breast cancers, and CBE will detect some cancers missed by mammography. (Screening guidelines promoted by the American Cancer Society are shown in Table 1.)

Radiologists prefer to have the results of the CBE available *prior* to the mammogram to guide both the imaging exam and its interpretation. Regardless of mammographic findings, all clinically suspicious CBE findings require further evaluation. Breast self-examination detects some breast cancers, but its accuracy as a screening modality alone is inferior to that of mammography and clinical breast examination.

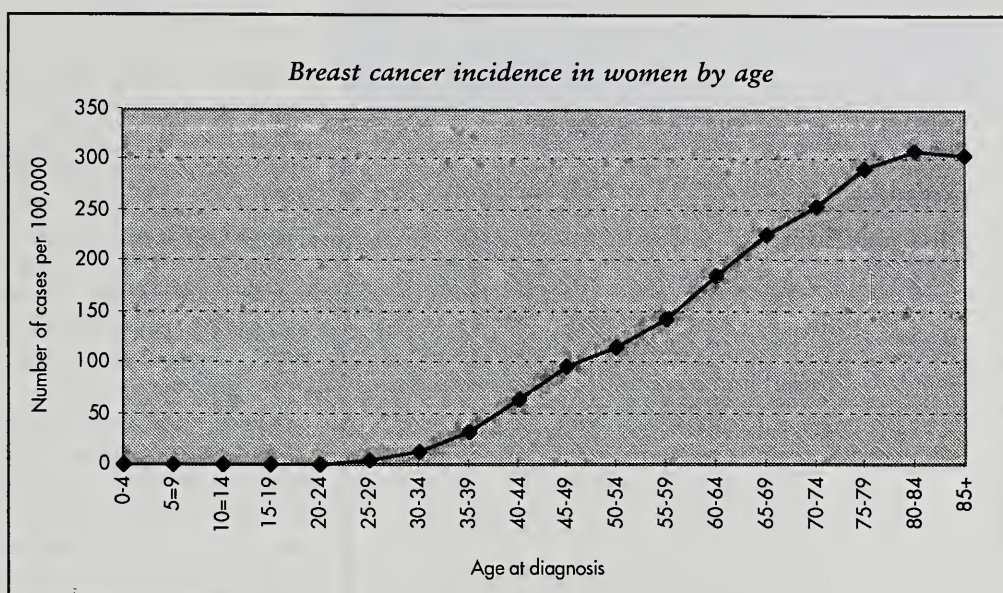


Figure 1

WHO CURRENTLY RECEIVES SCREENING?

Despite the demonstrated benefit of mammography with clinical breast examination, a significant proportion of women do not undergo screening for breast cancer. In the 1990 National Health Interview Survey, fewer than half of women age 50 and older reported having a recent mammogram, and screening occurred less frequently among older women, poor women, women of color, and women residing in rural areas.⁵ In the Minnesota Behavioral Risk Factor Survey, 65% of women age 50 and older reported receiving a mammogram and a clinical breast examination within the preceding two years (unpublished data, Minnesota Cancer Surveillance System). However, because these data are based on self-report, they probably overestimate true levels of screening. Furthermore, the data provide no insight into the proportion of women who receive *regular, annual screening*. Assessment of this parameter is key to gauging the success of efforts to promote breast cancer screening. Outcomes data produced by health plans based on medical claims also fail to consider *regular* screening, and at this time, population-based estimates are not available.

WHAT ARE THE BARRIERS?

Women and physicians continue to report significant barriers to the use and promotion of mammography. Physicians cite patient noncompliance and disinterest as major barriers to routine mammograms.⁶ On the other hand, women who do not receive mammograms cite a lack of perceived need and a lack of recommendation from a physician as the chief reasons.⁷ Moreover, the vast majority of women feel certain they would get mammograms in the coming year if their physicians ordered them, and few say they would get mammograms in the absence of a physician recommendation.⁸ Apparently, an

Table 1

American Cancer Society guidelines for early detection of breast cancer

Age 20-39	Clinical breast exam at least every three years
	Monthly breast self-exam
Age 40-49	Mammogram every one to two years
	Yearly clinical breast exam
	Monthly breast self-exam
Age 50 and over	Yearly mammogram
	Yearly clinical breast exam
	Monthly breast self-exam

Important:

These recommendations are intended for women who have no breast symptoms. See a doctor immediately if you find:

- a breast lump;
- fluid from nipples; or
- any other breast changes.

American Cancer Society Guidelines for Early Detection of Breast Cancer, from Cancer Facts and Figures—1995

Table 2

Minnesota Breast and Cervical Cancer Control Program (MBCCCP), Minnesota Department of Health**The Program**

- A **statewide** comprehensive breast and cervical cancer control program begun in 1992.
- Offers **free mammograms, clinical breast exams, and Pap smears** to eligible women through a network of **200 screening sites in 59 counties** throughout the state.
- **Available to women** with moderate or low incomes who are uninsured or underinsured.

Results

Total women screened	41,500
Total visits	66,500
Mammograms	24,000
CBEs done	49,500
Breast cancers found	143
Pap smears done	52,000
Invasive cervical cancers	11

To make a referral, call the American Cancer Society, 800/227-2345.

For more information on MBCCCP, call 612/623-5500.

important motivator for physicians to order mammograms is patient request, while the key for many women is physician recommendation. This is particularly true for older women. Obviously, these perceptions work against increased screening. In addition, although knowledge of mammography benefits seems widespread, most women do not adequately appreciate the role of aging as a primary risk factor, overemphasize the role of family history in determining personal risk, and draw the erroneous conclusion that mammography is unnecessary for them.⁹ For women with low incomes and no health insurance, cost and the lack of a primary source of care remain significant barriers.⁸ Certain other barriers exist for women from communities of color and from non-Western or non-English-speaking backgrounds. Culturally specific reactions to the concept of cancer and to Western medical assumptions, as well as language barriers, fear, embarrassment, and gender issues constitute some of the barriers women face. Older women are especially hampered by difficulties related to transportation, accessibility of services, and navigation of the medical care system.

HOW CAN PHYSICIANS HELP?

Physicians can play a significant role in closing the gap between current breast cancer screening practices and accommodating the needs of women. First, practicing physicians should consistently endorse the use of routine mammography and clinical breast examination. A comprehensive breast cancer screening and counseling program that focuses on optimizing outcomes while reducing barriers has been developed and tested. In addition to recommending mammography and a thorough clinical breast exam, this program suggests including breast self-exam instruction, risk review, barrier identification and counseling, review of mammography benefits and procedures, and open-ended questions and answers.¹⁰ Nurses, nurse practitioners, and health educators can help busy practices with this time-consuming but valuable program. Practices can improve compliance and reduce no-shows by providing transportation, free on-site child care, evening hours for working women, and patient advocates.

In Minnesota, barriers associated with lack of health insurance or insufficient insurance can be surmounted by referring eligible patients to the Minnesota Department of Health's statewide free breast and cervical cancer screening program (see Table 2). Multicultural materials, speakers, support services, and literature are available through the MDH program, the American Cancer Society, and through such Minnesota-based advocacy groups as the African American Breast Cancer Alliance, the YWCA ENCOREplus, and the Minnesota Breast Cancer Coalition.

CONCLUSION

As women's life expectancy continues to increase, as women become more involved with their health, and as the sizable baby-boomer generation enters its 50s, early detection and prevention of breast cancer will assume even greater importance for physicians and their women patients. Physician advocacy of breast cancer screening can bring many women peace of mind and achieve the public health objective of substantially reducing morbidity and mortality from this disease. MM

Jane Korn is medical director of the Cancer Control Section, Minnesota Department of Health, and Annette Bar-Cohen is head of the MDH's Education Unit for the Cancer Control Section.

The Minnesota Breast and Cervical Cancer Control Program (MBCCCP) is supported by Cooperative Agreement #U57/CCU506748 with the U.S. Centers for Disease Control and Prevention.

REFERENCES

1. Parker SL, Tong T, Bolden S, Wingo PA. Cancer statistics, 1996. *CA Cancer J Clin* 1996;65:5-27.
2. Miller BA, Ries LAG, Hankey BR, et al., eds. SEER cancer statistics review: 1973-1990. Bethesda, Maryland: National Cancer Institute, 1993. NIH Pub. No. 93-2789.
3. Fletcher SW, Black W, Harris R, et al. Report of the international

- workshop on screening for breast cancer. J Natl Cancer Inst 1993;85:1644-56.
4. Smigel K. Breast cancer death rates decline for white women. J Natl Cancer Inst 1995;87:173.
5. Breen N, Kessler L. Changes in the use of screening mammography: evidence from the 1987 and 1990 National Health Interview Surveys. Am J Public Health 1994;84:62-7.
6. Weinberger M, Saunders AF, Samsa GP, et al. Breast cancer screening in older women: practices and barriers reported by primary care physicians. J Am Geriatr Soc 1991;39:22-9.
7. NCI Breast Cancer Screening Consortium. Screening mammography: a missed clinical opportunity? JAMA 1990;264:54-8.
8. Zapka JG, Costanza ME, Stoddard A, Green HL. Breast cancer screening: perceptions and experience of primary care physicians, radiologists and women. Prog Clin Biol Res 1990;339:253-7.
9. O'Connor AM, Perrault DL. Importance of physician's role highlighted in survey of women's breast screening practices. Can J Public Health 1995;86:42-5.
10. Costanza ME, Greene HL, McManus D, Hoople NE, Barth R. Can practicing physicians improve their counseling and physical examination skills in breast cancer screening? J Cancer Educ 1995;10:14-21.

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- Infectious Diseases in the Workplace, Earle Brown Center, St. Paul Nov. 21
- Fitting the Work to the Worker, Holiday Inn International, Bloomington
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RAMSEY

Clinical Breast Examinations

Avoiding Misunderstandings

With complaints to the BMP regarding breast exams on the rise, physicians should follow these guidelines to increase patient comfort.

Alison J. Coulter, M.D., Robert Leach, J.D., and Edward Maeder, M.D.

Breast cancer screening remains an effective means of detecting breast cancer—the most prevalent cancer in women and the most deadly of cancers for women aged 40 to 55. Yet, despite its usefulness, the clinical breast exam is often avoided by women and their physicians. Patients may be unsure what to expect during the procedure and, unfortunately, physicians don't always offer sufficient explanation, and they may use techniques that add to a woman's discomfort. Resulting misunderstandings may leave the patient confused and embarrassed, and perhaps even worried that her physician acted inappropriately. In growing numbers, women are contacting the Minnesota Board of Medical Practice with questions and complaints about their physicians' actions during a clinical breast exam. Well aware of such complaints, physicians, in turn, are becoming increasingly uneasy about performing these important exams.

To encourage breast cancer screening and to help alleviate patient and physician concerns about the clinical breast exam, the Board of Medical Practice (BMP) and the Minnesota Medical Association are working together to educate both the public and physicians about what normal breast exams involve and when physicians should conduct them.

SEXUAL MISCONDUCT ALLEGATIONS

In recent years, managed care organizations, licensure boards, the legal profession, and the public have begun to scrutinize the practice of medicine, including physician conduct. One area of particular concern is physician sexual misconduct. The heightened awareness of sexual misconduct and its potentially devastating effects on patients led to legislation that makes it a crime for physicians to have sexual relationships with patients.¹ In addition, the Minnesota Medical Practice Act² was amended in 1985 to include sexual misconduct as grounds for disciplinary action. These legislative changes, combined with greater public sensitivity and media coverage, have resulted in a marked increase in complaints to the Minnesota Board of Medical Practice alleging sexual misconduct.

Every complaint of a potentially sexual nature made to the BMP is referred directly to the Attorney General's Office for full investigation. The performance of breast exams has emerged as a concern in Minnesota (and elsewhere), as evidenced by the number of complaints the board has received. In the biennial period ending June 30, 1994, the Minnesota BMP received 227 complaints alleging conduct of a sexual nature. Approximately 54 of those complaints included inappropriate breast exams and involved 31 licensees. About half

of those complaints (25) were dismissed, usually because no evidence supported sexual misconduct. Fourteen resulted in an order restricting the physician's license in some way, and three complaints resulted in a corrective action agreement (usually educational) when the board found that the allegations did not constitute sexual misconduct, but rather minor boundary or communication problems. Ten complaints were pending at the time of the biennial report. Some of the complaints received a great deal of notoriety in the press, further increasing physician and patient discomfort.

The BMP has received a variety of complaints about the way breast exams are conducted. For example, one woman complained that a breast exam was performed every time she saw her physician, even when she was in the office for an unrelated problem. Some women said their physicians made inappropriate comments about the size of their breasts (in one instance, the physician was attempting to be humorous and put the woman at ease but offended her instead). One woman claimed her doctor "ogled" both breasts at the same time, when, in fact, the physician was inspecting the breasts for asymmetry. Other patients complained that their physicians took too long to perform the exam or used a technique with which the patients were not familiar.

Although many women believe they know exactly how a breast exam

should be done based on their own experiences and on articles about breast exams they've read in the lay press, they may not be fully informed about available, appropriate techniques. This may, in part, explain why many complaints about breast exams result from misunderstandings and inadequate communication and do not involve sexual misconduct. Although these complaints are dismissed, they nonetheless create distress for patients and physicians.

Many physicians have told the BMP they are uneasy about performing breast exams because of the risk of a complaint. Some physicians have become reluctant to do them at all. Recently, a prominent Twin Cities physician and past member of the BMP contacted board staff to express his concerns. "I, frankly, have stopped doing breast exams entirely and refer all my patients to an ob/gyn even though it would be cheaper and faster for me to do the exams," he stated, adding that a number of his colleagues feel the same way. "Most physicians tell me they have stopped doing the exam ... especially the sitting and standing part with the patients in various positions exposing the breasts. [Physicians] are also concerned about the length of time, indicating the longer they do the exam the more uncomfortable they become and wonder what the patients are thinking," he said.

RECOMMENDING THE BREAST EXAM

Although recommendations regarding the timing of breast exams is controversial, most physicians still believe it is an important component of the routine female medical exam (see related article, page 26). The methods of screening include breast self-examination (BSE), clinical breast examination (CBE), and mammography. It is prudent to recommend a breast examination as part of any preventive health care check for women age 18 and older. The risk of breast cancer increases with a woman's age, and after age 40, an annual CBE should be performed.³ Physicians should identify women who are at high risk for breast cancer and

make screening recommendations accordingly. For example, women age 35 and older who have a first-degree relative diagnosed with premenopausal breast cancer would be candidates for yearly CBE and mammography.³ Equally important is the physician's opportunity to educate women about the prevalence of breast cancer and the techniques of BSE.

CONDUCTING A THOROUGH BREAST EXAM

Because of the nature of a breast examination, it is essential that physicians communicate their intentions of conducting a thorough exam. This seems to be of particular importance if the patient presents to the physician's office for reasons other than an annual examination or for complaints not related to the breast. Patients are far more knowledgeable and involved in their medical care than in past decades. Good physicians no longer dictate their plans to patients, but rather negotiate plans acceptable to the patient. This more open approach generally leads to greater understanding for both parties, as well as better patient compliance, and is recommended when performing a breast exam. Most patients respond positively to even very brief explanations.

A systematic examination is most effective for both the CBE and the BSE. Before the actual clinical exam, a brief history of breast complaints should be documented. Reported symptoms of breast pain and nipple discharge would increase the physician's suspicion of possible underlying breast pathology. Also, physicians should document any family history of breast cancer, especially premenopausal, in first-degree relatives.

The physician should begin the CBE by visually inspecting the breast, looking for subtle changes in the skin and underlying tissue. This can often be done quickly during the palpation part of the exam to avoid causing the patient uneasiness or embarrassment. In patients under age 40 not at high risk for breast cancer, the breast can be examined while the woman is supine. Many patients, particularly

younger women, find this type of breast exam more acceptable. It is important, however, to examine women over age 40 and women at high risk for breast cancer in both the sitting and supine positions. The physician should palpate all areas of the breast, including the axillary and supraclavicular lymph node regions. The nipples should be checked for evidence of abnormal discharge. Finally, the physician should carefully document the breast exam in narrative form and often with a diagram, specifically noting any problems with the exam, such as unusual embarrassment or discomfort experienced by the patient. Written documentation is helpful when patients return for follow-up, and it is important if legal questions arise.

HELPING THE PATIENT FEEL COMFORTABLE

Although no one is immune to complaints, physicians can do many things to make women feel more comfortable and to avoid misunderstandings related to breast exams. The following suggestions are in response to complaints women commonly make.

- Consider having a female assistant in the room when performing a breast exam. Although this is not the standard of care in Minnesota, it may increase patients' comfort. Many clinics now ask patients if they would like to have someone else present. Patients with a history of sexual abuse are more likely to feel victimized, and physicians may find it especially prudent to have a support staff present for such patients.

- Modify exams to fit patients' complaints, as opposed to performing a complete exam at every visit. If the patient has not had an up-to-date breast exam, offer to do one.

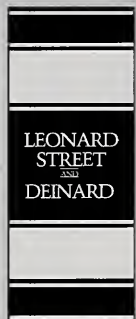
- Provide privacy for the patient to undress. Do not unfasten a patient's bra or other articles of clothing. Many women feel such actions are associated with sexuality.

- Knock before you enter the exam room.

- Explain to the patient what you are doing and, when appropriate, why.

- Be alert to the patient's and

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your nonverbal communication. If the patient seems uncomfortable, stop and explore the reasons.

- Use current exam techniques. If you deviate from your routine to better examine a specific area of a breast or large breasts, explain to the patient the need to do so.

- Whenever possible, cover the breast that is not being examined.

- If you happen to say or do something that you realize could be misinterpreted, try to clarify rather than ignore it.

- If you are a subspecialist who does complete physical exams when evaluating new patients, communicate this to the patient in advance either by providing her with a brochure or by having your office staff explain the evaluation ahead of time. Allow patients the opportunity to decline portions of the exam.

- For the new or younger patient, conduct the interview portion of the exam before the patient undresses to decrease anxiety.

- Limit physical contact with the patient to only what is necessary to conduct your examination.

By using these techniques, physicians can provide their patients appropriate, thorough breast exams while ensuring their comfort. The BMP and the MMA would like women to receive regular, appropriate breast exams and hope that by educating physicians and female patients, we will help eliminate complaints resulting from these exams. **MM**

Alison Coulter is a family practice physician at Physicians Neck and Back Clinic in Roseville, Minnesota, and medical coordinator for the Minnesota Board of Medical Practice (BMP). Robert Leach is executive director of the BMP. Edward Maeder is a fellow of the American College of Obstetricians and Gynecologists, a physician at Park Nicollet Clinic, and a clinical professor at the University of Minnesota.

REFERENCES

1. Minn. Stat. Chapter 609.344 and 345.
2. Minn. Stat. Chapter 147.
3. Visscher HC, ed. Primary and preventive care: a primer for obstetricians and gynecologists. Washington, D.C.: American College of Obstetricians and Gynecologists, 1994.

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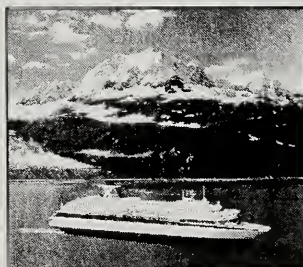
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ANNOUNCEMENTS

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The MMA House of Delegates elected the following officers and AMA delegates and alternates.

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Carolyn J. McKay, M.D.

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Raymond G. Christensen, M.D.

Kenneth W. Crabb, M.D.

Theodore L. Fritsche, M.D.*

John Van Etta, M.D.*

*Reelected.

Raymond G. Christensen, M.D., was inaugurated president.

The November issue of *The Monitor* will include news of the 1996 MMA Annual Meeting.

...

YOU ARE INVITED TO THE MMA/MSBA BREAKFAST

Telemedicine is the topic of the Minnesota Medical Association/Minnesota State Bar Association breakfast meeting to be held October 15 from 7 a.m. to 9 a.m. at the Sheraton Inn Midway in St. Paul. Among the speakers are Thomas Greeson, J.D., of the American College of Radiology and Leo Whalen, J.D., of the legal department of the Mayo Clinic in Rochester. For more information, call Vicki Westling at the MMA, 612/378-1875 or 800/999-1875.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

Antitrust Barriers to Physician Networks Are Eased

New federal regulations will make it easier for physician networks to compete with managed care plans without running afoul of antitrust laws. The Federal Trade Commission and the Justice Department have announced that they will apply a more flexible legal standard to determine whether physician-run networks violate antitrust laws. This is a victory for the AMA, which has lobbied long and hard on this issue. "The revised guidelines should result in more choice for patients, more competition, and better health care," said Daniel H. "Stormy" Johnson Jr., M.D., AMA president.

Physician Fee-For-Service Networks OKed

The old guidelines limited physician networks to those in which the physicians assumed substantial financial risk through capitation or "withholds" large enough to influence practice patterns. Such networks require a large amount of capital to organize and operate as well as skill in managing insurance risk. Other kinds of physician networks such as fee-for-service arrangements were subject to the "per se" rule, which automatically judged any discussion of fees to be illegal price fixing. The AMA argued that this made it virtually impossible for physicians to form fee-for-service networks.

Under the new policy, however, physician networks that use fee-for-service or other arrangements will have an opportunity to demonstrate their merits under a "rule of reason"

rather than being judged according to the "per se" rule. Regulators will consider whether the benefits of a network outweigh its potential to be anticompetitive. Physicians in a joint venture will no longer have to share financial risk, but they must cooperate in an "active and ongoing program" to contain costs and ensure quality of care.

Larger Networks Allowed

The new policy also clarifies that physician networks don't have to fall within specific antitrust "safety zones" to be legal. The AMA believes it is possible for physician networks to have 50 percent or more of the physicians in a specialty in competitive markets where there are many physicians who would be available to form competing networks, or many other networks, or if there is a divergence of economic interests among the physicians in a network. The new policy allows physician-run plans to offer their patients a wider choice of physicians.

"While today's action represents a milepost, we still have a way to go before we reach a level playing field," Johnson said. The AMA will continue to work with Rep. Henry Hyde, R-Ill., chair of the House Judiciary Committee, who sponsored a bill to require a rule of reason approach to physician networks.

"Physicians should be aided by experienced counsel as they develop networks," said Edward Hirshfeld, vice president and associate general counsel of AMA's health law divi-

Antitrust continued on page 34

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Antitrust continued from page 33

sion. "With the new guidelines there is now enough guidance available to counsel that physicians should insist on getting definite advice – physicians should not accept evasive opinions from their antitrust counsel."

If you have questions about the new guidelines, call Patricia Franklin, director of the MMA legal department, at 612/378-1875 or 800/999-1875.



MEDPAC

Dear Colleague,

The Minnesota Medical Political Action Committee Board of Directors urges you to vote for these MEDPAC-endorsed candidates. As a leader in your community, you are well aware of the importance of voting on November 5, 1996. This year the entire Minnesota Legislature, all eight U.S. Congressional seats, and one U.S. Senate seat are up for election. The winners of these races will be making decisions that will affect your practice and your patients.

This list of MEDPAC endorsements is the result of long hours of interviewing candidates and researching and analyzing the races. Decisions were based on three criteria:

- the candidate's position on issues that are important to Minnesota physicians,
- the candidate's ability to win,
- input from physicians and alliance members in the candidate's district.

Please note that MEDPAC chose not to endorse either candidate in some races. MEDPAC endorsements reflect a conviction that the candidate will be willing to support the MMA on the most crucial issues.

I urge you to support the MEDPAC-endorsed candidates, not only with your vote, but also by participating in the 1996 campaigns. Legislators appreciate the help of constituents who attend or host fundraisers, distribute campaign literature, or staff phone banks.

If you have any questions, please call MEDPAC at 612/378-1875 or 800/999-1875.

Sincerely,

John Dowdle M.D.
 Chair, MEDPAC



MEDPAC

Minnesota Political Action Committee Endorsements for the 1996 Elections

U.S. Senate

No Endorsement

U.S. House of Representatives

Dist. 1 - Gil Gutknecht, R
Dist. 2 - David Minge, DFL
Dist. 3 - Jim Ramstad, R
Dist. 5 - Martin Sabo, DFL
Dist. 7 - Collin Peterson, DFL

Dist. 48 - Don Betzold, DFL
Dist. 49 - Ron Bradley, R *
Dist. 53 - Linda Runbeck, R
Dist. 55 - Chuck Wiger, DFL *
Dist. 58 - Linda Higgins, DFL *
Dist. 60 - Allan Spear, DFL
Dist. 61 - Linda Berglin, DFL
Dist. 63 - Jane Ranum, DFL
Dist. 64 - Richard Cohen, DFL

Dist. 32B - Michelle Rifenberg, R *
Dist. 34B - Todd Van Dellen, R
Dist. 35A - Carol Molnau, R
Dist. 35B - Becky Kelso, R
Dist. 36A - Eileen Tompkins, R
Dist. 36B - Dan McElroy, R
Dist. 37B - Bill Macklin, R
Dist. 38A - Tim Commers, R
Dist. 38B - Tim Pawlenty, R
Dist. 39A - Thomas Pugh, DFL
Dist. 41A - Alice Seagren, R
Dist. 42A - Ron Erhardt, R
Dist. 42B - Erik Paulsen, R
Dist. 43B - Barbara Sykora, R
Dist. 44A - Rob Samuelson, R *
Dist. 44B - Jim Rhodes, R
Dist. 45A - Ron Abrams, R
Dist. 45B - Peggy Leppik, R
Dist. 46A - Ann Rest, DFL
Dist. 48A - Bill Haas, R
Dist. 49A - Charlie Weaver, R
Dist. 50A - Tom Hackbarth, R *
Dist. 50B - Kathy Tingelstad, R *
Dist. 51A - Mike Delmont, DFL
Dist. 52A - Skip Carlson, R *
Dist. 53A - Phil Krinkie, R
Dist. 53B - Sherry Broecker, R
Dist. 56A - Mark Holsten, R *
Dist. 57A - Nora Slawik, DFL *
Dist. 62A - Lee Greenfield, DFL
Dist. 63A - Jean Wagenius, DFL
Dist. 64B - Ray Cleveland, R *

State Senate

Dist. 1 - LeRoy Stumpf, DFL
Dist. 2 - Roger Moe
Dist. 4 - Brad Nord, R *
Dist. 8 - Becky Lourey, DFL *
Dist. 10 - Cal Larson, R
Dist. 15 - Dean Johnson, R
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Dist. 21 - Arlene Lesewski, R
Dist. 23 - Dennis Frederickson, R
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Dist. 26 - Tracy Beckman, DFL
Dist. 30 - Sheila Kiscaden, R
Dist. 35 - Claire Robling, R *
Dist. 36 - David Knutson, R
Dist. 38 - Deanna Wiener, DFL
Dist. 40 - Dave Johnson, DFL *
Dist. 41 - William Belanger, R
Dist. 42 - Roy Terwilliger, R
Dist. 43 - Ed Oliver, R
Dist. 44 - Mark Sathe, R *
Dist. 45 - Martha Robertson, R
Dist. 46 - Ember Reichgott Junge, DFL

State House of Representatives

Dist. 4A - Jeff Aakhus, R *
Dist. 6B - Thomas Huntley, DFL
Dist. 8B - Jim Taylor, R *
Dist. 9A - Kevin Goodno, R
Dist. 9B - Bob Westfall, R *
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Dist. 21A - Mary Seifert, R *
Dist. 21B - Richard Mulder, M.D., R
Dist. 23A - Barb Vickerman, R
Dist. 24B - Richard McCluhan, R *
Dist. 28A - Doug Reuter, R *
Dist. 28B - Steve Sviggum, R
Dist. 30A - Fran Bradley, R
Dist. 30B - Dave Bishop, R
Dist. 31B - Greg Davids, R

*Open Seat

'Stop the Violence Day at the Dome' Begins Child Health Month

Stop the Violence Day at the Dome" on September 29 kicked off a month of violence prevention activities during October, which is Child Health Month.

Established four years ago by the American Academy of Pediatrics (AAP), Child Health Month is a major public awareness effort held every October to focus attention on the importance of preventive health care for all children. This year, the Minnesota Medical Association and many other organizations and agencies are joining together to concentrate on prevention strategies aimed at protecting children from the impact of violence.

Child Health Month

Some key messages of Child Health Month are:

- Don't hit your children.
- Make sure your children do not have access to guns.
- Try to keep your children from seeing violence in the home or community.

Violence Prevention

"Stop the Violence Day at the Dome" began with a pregame rally on the plaza with music by Umoja, an African-American drum corps. During the pregame show inside the Dome, MMA president Raymond G. Christensen, M.D., and Minnesota Attorney General Hubert H. Humphrey III spoke about the importance of protecting children from violence. The first 1,000 youngsters to attend the game received a free "Stop the Violence Day at the Dome" T-shirt.

'Stop the Violence Day at the Dome'

In the Dome concourse, sports fans picked up information about violence prevention at the various display booths. The MMA booth featured the brochures, "Ten Tips for

Parents on Media Violence" and "Unload it & Lock It," the MMA gun safety brochure. The Child Health Month booth included information on violence prevention by its member organizations, which include the Minnesota Medical Association, Hennepin Medical Society, the United Way of Minneapolis, Minnesota Academy of Pediatrics, North Memorial Medical Center, the University of Minnesota Department of Pediatrics, Hennepin County Medical Center, Southlake Clinic, Children's Health Care, Fairview Ridges Hospital, Fairview Riverside Medical Center, Fairview Southdale Pediatrics, Unity Hospital, St. Paul Children's Hospital, the Foundation HealthSystem Minnesota and many more.

"Stop the Violence Day at the Dome" was sponsored by the Minnesota Medical Association, Attorney General Hubert H. Humphrey III, Ramsey/Hennepin Initiatives for Violence Free Families & Communities, University of Minnesota's Children, Youth and Family Consortium, and WomanKind Fairview Health System. It is cohosted by many health care organizations, including Minnesota Cable Communications Association, Minnesota Hospital and Healthcare Partnership, Minnesota Nurses Association, Minnesota Council of HMOs, Center for Reducing Rural Violence/Citizens Council, Allina, Blue Cross and Blue Shield of Minnesota, HealthPartners, Citizens for a Safer Minnesota, Ramsey Medical Society, and Hennepin Medical Society.

SAVE-A-SHELTER

The AMA and the AMA Alliance are joining together in a campaign called SAVE-A-SHELTER. Beginning on SAVE TODAY, October 9, they are urging physicians and physician spouses across the nation to adopt

an abuse shelter, transition home, rape crisis center, or other establishment serving victims and their children.

To honor both Child Health Month and SAVE TODAY, the Minnesota Medical Association Alliance and the Hennepin Medical Society Alliance is adopting the new Crisis Nursery Northwest, which plans to open its doors in December 1996. The crisis nursery will provide a safe haven for newborns through age six for up to 72 hours at no charge to their parents. The existing Minneapolis Crisis Nursery sheltered 1,999 children in 1995 and was forced to turn away nearly 2,500 more children. The new crisis nursery needs rocking chairs, diapers, children's clothes, toys, sheets, towels, etc. — everything it takes to run a household with small children. The MMA Alliance will hold a "baby shower" for the crisis center in conjunction with its fall meeting October 10 in Stillwater. To donate to the shelter, call Karen Tourdot at the MMA 612/378-1875 or 800/999-1875.

• • • • •

MMA Firearm Safety Brochure 'Unload It & Lock It'

• • • • • **THE MINNESOTA MEDICAL Association** brochure, "Unload It & Lock It," includes guidelines on how to safely store firearms. To obtain brochures for your patients, call Beth Hoheisel at 612/378-1875 or 800/999-1875. The brochure can be used as a poster in your waiting room.

The MMA brochure was funded by Allina Health System, Blue Cross Blue Shield of Minnesota and HealthPartners, and it was endorsed by Attorney General Hubert H. Humphrey III, the Department of Natural Resources, the MMA, and the MMA Alliance.

AMA Promotes MMA Campaign to Stop Media Violence

The American Medical Association unveiled "Virtual Violence," a national campaign based on the Minnesota Medical Association's award-winning "Stop the Media Violence" campaign at a news conference in Chicago September 9. Three Minnesotans, who have been active in the MMA campaign, addressed reporters: Attorney General Hubert H. Humphrey III, David Walsh, Ph.D., a psychologist at Fairview Behavioral Services, and Marjorie Hogan, M.D., a Minneapolis pediatrician representing the Minnesota Medical Association and the American Academy of Pediatrics.

The AMA "Virtual Violence" campaign grew out of a Minnesota resolution to the AMA House of Delegates that called on the AMA to promote the MMA's successful media violence campaign throughout the nation.

MMA 'Stop the Violence' Campaign

The MMA expanded its ongoing campaign against family violence to include media violence in 1995. In partnership with Minnesota Attorney General Hubert Humphrey and the Allina Foundation, the MMA launched a major effort to help Minnesota physicians and parents reduce the amount of violent programming that children watch. One year later, approximately 1,000 medical clinics in Minnesota have joined the campaign, and the MMA has distributed more than 150,000 copies of its brochure, "Ten Tips for Parents to Stop the Media Violence," to physicians, clinics, churches, schools, and other community resources.

AMA 'Virtual Violence' Campaign

At the news conference, the AMA announced that 60,000 physicians nationwide will receive a new publication, *The Physician Guide to Media Violence*. Like the MMA bro-

chure, this guide includes tips for parents on how to reduce the family's exposure to media violence.

The AMA also announced that it is teaming up with the National Association of Attorneys General (NAAG) to encourage grassroots partnerships among health care and law enforcement groups, based on the Minnesota model. Speaking at the news conference, Humphrey said, "NAAG and the attorneys general have long been concerned with the issue of violence in our society, but violence is not simply a legal problem. By the time the legal system becomes involved, it is often too late for victims and for society. It seems only appropriate that we begin to partner with the AMA. Physicians are witnesses to the very real consequences of violence."

Media Violence Harms Children

Study after study has confirmed that media violence translates into real-life violence. "The steady diet of violent entertainment that we have fed to our children has created and nourished a culture of disrespect," said David Walsh, Ph.D., author of "Selling Out America's Children," who helped the MMA and AMA develop its guidelines. "Violence is the ultimate act of disrespect. We've gone from 'Have a nice day' to 'Make my day.' That's what we've taught our children."

On average, by the age of 12, American children have seen 8,000 murders on TV. By the time they graduate from high school, they have witnessed more than 200,000 acts of television violence. Prime-time television displays on average five to six violent acts per hour. Saturday morning children's TV programs display 20 to 25 violent acts each hour.

Promotion continued on page 38



Attorney General Hubert H. Humphrey III; David P. Walsh, Ph.D., a psychologist at Fairview Behavioral Services; John Nelson, M.D., AMA trustee; and Marjorie Hogan, M.D., a pediatrician representing the Minnesota Medical Association and the American Academy of Pediatrics.

ANNOUNCEMENTS

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BROCHURES ARE AVAILABLE

The American Academy of Pediatrics brochures, "How to Raise a Non-Violent Child," and "Healthy Communication with Your Child: A Guide for Parents," provide helpful information for parents. The minimum order is 100 brochures. The price for brochures is \$24.95/100 for members and \$29.95/100 for nonmembers. To order, write the American Academy of Pediatrics, Division of Publications, 141 Northwest Point Boulevard, P.O. Box 927, Elk Grove Village, IL 60009-0927.

...

PVS ANNOUNCES NATIONAL CONFERENCE 'ALCOHOL: FUEL FOR FAMILY VIOLENCE?'

Physicians for a Violence-Free Society presents its national conference entitled, "Alcohol: Fuel for Family Violence? The Medical Response & Responsibility," February 7 to 9, 1997, in San Francisco. Sessions will address the impact of alcohol abuse on family violence. Topics will include societal barriers to prevention, provider wellness, and a team approach to finding practical solutions. The conference will be held in the Hyatt at Fisherman's Wharf. The early registration fee is \$250 for PVS members and \$300 for nonmember. After January 1, 1997, the fee increases by \$50. To register, or for more information, call JoAn Dwyer at 214/590-8807.

Promotion continued from page 37

Public Responds to Campaign

"The MMA has had a tremendous response to its campaign against media violence," said Michael J. Murray, M.D., president of the MMA. "Physicians are aware that watching violent programs is unhealthy for children and we want to serve as a resource for our patients. The strong interest in the MMA campaign shows that parents want to reduce their children's exposure to violence."

Results of an AMA national survey confirm this. Three-quarters of American parents are turning off their televisions and walking out of movie theaters because of excessive violence.

"Violence is a preventable health care problem, and prevention is our business," said David Strand, system vice president for market and net-

work management of Allina Health System, which provides support to the independent Allina Foundation. "Allina took leadership in supporting these programs because we want to improve health for the entire community."

The American Medical Association and the National Association of Attorneys General, were joined by the American Hospital Association, the American Association of Health Plans, along with Minnesota's Allina Foundation and Fairview Health System in providing funding for *The Physician Guide to Media Violence*.

The MMA "Stop the Media Violence" campaign, which included posters, physician guidelines, buttons, bumper stickers, brochures, radio and television public service announcements, slide presentations, and articles, received an Associations Advance Minnesota Award from the Minnesota Society of Association Executives in 1996.

YOU CAN HELP

PULL THE PLUG ON**VIOLENCE****PULL THE PLUG ON VIOLENCE WEEK****OCTOBER 20 - 26, 1996**

By watching violent programs and playing violent video games, your children may be learning to:

- **FIGHT OR USE VIOLENCE TO SOLVE PROBLEMS**
- **THINK VIOLENCE IS FUNNY, RATHER THAN PAINFUL AND REAL**
- **PRACTICE OR USE VIOLENT ACTS JUST LIKE THEIR FAVORITE TV OR VIDEO GAME CHARACTERS**

**OCTOBER IS CHILD HEALTH MONTH**

ANNOUNCEMENTS

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CALL HEALTHPARTNERS FOR DOMESTIC VIOLENCE VIDEO

"Domestic violence is not a medical issue."

"I don't have time to screen my patients."

"What's the use? Battered women never leave."

The video, "Domestic Violence: How to Ask and What to Say for Health Care Professionals," is designed to dispel myths about family violence and help physicians intervene and provide assistance to victims and children. This 22-minute video, produced by HealthPartners, shows three different physician-patient vignettes that illustrate ways to screen and intervene in cases of domestic violence.

Many barriers prevent victims of domestic violence and their children from getting the help they need to break the cycle of domestic violence. Some victims feel ashamed and guilty about their abuse; others fear their partner may retaliate if they tell anyone. Health care providers cannot "fix" the problem of domestic violence, but they do have a unique opportunity to listen in a nonjudgmental fashion and offer resources and information to the victims.

The video may be purchased for \$5 by calling HealthPartners, Center for Health Promotion at 612/883-6745 or writing to 8100 34th Avenue South, PO Box 1309, Minneapolis, MN 55440-1309.

AMA Commends Health Insurance Reform Bill

The American Medical Association credits strong grassroots physician support for passage of a national health insurance reform bill that addresses many of the concerns of organized medicine. The Health Insurance Portability and Accountability Act of 1996, introduced by Sens. Edward Kennedy, D-Mass., and Nancy Kassebaum, R-Kan., was signed into law in August. Most provisions take effect in July 1997.

Fraud and Abuse

"The bill strikes a delicate balance of affording government agencies the tools they need to catch fraudulent health care providers, while ensuring that providers who make innocent mistakes or billing errors will not be punished," according to the AMA. Only a physician who acts "knowingly and willfully" to defraud federal health care programs can be prosecuted for fraud. Civil money penalties can be imposed only if a physician acted "knowingly" and with either "reckless disregard for," or with "deliberate indifference to" the truth of statements made in physician billing records. In addition, the law calls for advisory opinions to inform physicians whether specific business practices violate the law.

Insurance Reforms

The Kennedy-Kassebaum bill will help people keep their insurance coverage if they have preexisting medical conditions and if they lose or change jobs. It also ensures portability of health insurance for people who move from group coverage to individual coverage and guarantees the availability and renewability of insurance coverage in the small group and individual health insurance markets. These provisions will not have as much of an impact in Minnesota as in other states because MinnesotaCare legislation enacted similar reforms. But Minnesota's self-insured market will now have to follow the

portability requirements and Minnesotans who must apply for new insurance coverage because of a job loss will have 63 days to apply for new coverage instead of the 30 days they had under Minnesota law.

Medical Savings Accounts

The Kennedy-Kassebaum bill includes a pilot project for medical savings accounts (MSAs). Controversy over MSAs stalled the bill for months, but legislators finally agreed on a compromise calling for a four-year trial project of 750,000 MSAs for the self-employed and for businesses with 50 or fewer employees. To participate in an MSA, the taxpayer must be covered by a high-deductible insurance plan. At the end of the four-year experiment, Congress will have to decide whether to pass legislation to extend or expand the program. Participants in the pilot program will be allowed to keep their MSAs.

Medical Liability

The bill extends the Federal Tort Claims Act protections to physicians who volunteer health care services to the poor.

Mental Health Parity

The mental health parity provision in the Senate bill, which was proposed by Sen. Paul Wellstone, D-Minn., was not included in the final bill because of fears it would increase premium costs. The provision would have required insurers to offer coverage for mental health benefits on a par with other medical benefits. Wellstone and Sen. Pete Domenici, R-N.M., later introduced legislation to require that aggregate and annual payment limits for mental illness be the same for mental and physical illnesses. This measure was amended to a fiscal 1997 spending bill and has been included in the House/Senate conference bill.

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A N N O U N C E M E N T S

AMA URGES SUPREME COURT TO REVIEW ASSISTED-SUICIDE DECISIONS

The American Medical Association has filed an amicus brief urging the U.S. Supreme Court to accept for review the assisted-suicide decisions of the 9th and 2nd U.S. Circuit Courts, which have been interpreted as opening the door to physician-assisted suicide. The AMA is joined in filing the brief by the California Medical Association and the Society of Critical Care Medicine. The brief alludes to the "profound and harmful impact that the Ninth Circuit's decision will have on the trust between physician and patient that is crucial to the physician-patient relationship and to the integrity of the medical profession." If the Supreme Court accepts either or both cases, the AMA and other medical organizations will have the opportunity to file a brief on the merits of the case.

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JCAHO ACCEPTS OFFICE LAB ACCREDITATION

Effective immediately, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will recognize and accept the accreditation process, findings, and decisions of the Commission on Office Laboratory Accreditation (COLA) when surveying integrated delivery systems and health plans. The cooperative agreement is designed to reduce duplication of evaluations of on-site laboratories in integrated organizations surveyed under JCAHO's network accreditation program.

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HTAC ISSUES REPORT ON BONE MARROW TRANSPLANTATION FOR BREAST CANCER

HTAC's report, "Autologous Bone Marrow Transplantation or Periph-

eral Blood Stem Cell Transplantation after High Dose Chemotherapy for Breast Cancer," found there is not enough data to resolve the controversy over whether high dose chemotherapy with autologous bone marrow transplantation and/or peripheral blood stem cell transplantation improves survival rates in breast cancer patients compared with standard dose breast cancer treatment. Data from randomized controlled trials are needed.

The report reached the following conclusions:

- High dose chemotherapy (HDC) with autologous bone marrow transplantation (ABMT) or peripheral blood stem cell transplantation (PBSCT) is a promising treatment for breast cancer. But, there is controversy over whether the improved response rates observed after HDC translate into significant health benefits that justify the risks of serious treatment-related complications and death.
- For some patients high costs are associated with this treatment, compared to standard dose chemotherapy.
- Well-designed, randomized, clinical trials comparing state-of-the-art, standard-dose chemotherapy to HDC with ABMT and/or PBSCT, controlling for cancer stage, treatment history, and other relevant patient factors such as age and estrogen receptor status, are necessary to resolve the controversy.
- The National Cancer Institute is sponsoring randomized, controlled clinical studies with adequate patient populations, strict patient inclusion criteria, and well-defined outcome parameters. Because there is not yet sufficient patient enrollment in these crucial studies, the data needed to determine the long-term effectiveness and safety of HDC with BMT and/or PBSCT for breast cancer treatment

compared with standard therapies for the disease are not yet available.

- Whether HDC with ABMT and/or PBSCT can improve patient survival at acceptable levels of morbidity, mortality, and costs to the health care system cannot be answered without data from randomized controlled trials.

HTAC WILL STUDY FEMALE BONE DENSITY, CORONARY ARTERY SCANS

The Health Technology Advisory Committee will study the following health technology issues:

- bone density screening for women,
- ultrafast CT and PET scans for detection of coronary artery disease,
- otoacoustic screening in newborns,
- HIV testing for pregnant women, and
- genetic testing for breast cancer.

The Monitor

OCTOBER 1996

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The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

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The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

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Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "title (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

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Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

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References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—not alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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Barriers to Screening and Counseling Pregnant Women for Alcohol Use

Kimberly J. Miner, Ph.D., Neal Holtan, M.D., M.P.H., Mary E. Braddock, M.D., M.P.H., Hanna Cooper, M.P.H., and Doreen Kloeckner, M.A.

ABSTRACT

The consequences of fetal alcohol exposure are far-reaching and preventable. Health care providers are uniquely positioned to promote alcohol-free pregnancy, yet an array of factors inhibit routine screening, counseling, and referral. This descriptive, qualitative study explored experiences and perceived barriers related to prenatal screening for alcohol use. The study included eight focus groups (71 participants) and 41 key informant interviews with health care professionals representing a mix of disciplines. Nearly 40% of the providers were physicians who regularly encounter women in their practices. While most providers ask about alcohol use, few probe in depth or follow up. The findings should alert program planners and medical educators to strengthen their preventive medical and public health practices.

The adverse health and economic consequences of fetal alcohol exposure are increasingly documented in the medical and public health literature.¹⁻³ A growing body of research links poor birth outcomes not only to chronic heavy drinking (an average of two or more drinks per day), but also to episodic heavy drinking (five or more drinks on one drinking occasion, also known as binge drinking).^{2,4} These findings are particularly noteworthy for Minnesota, which ranks well above the national median in the rate of frequent drinking among women of childbearing age. Nearly one in five (18.2%) Minnesota women aged 18 to 44 years report frequent drinking (an average of one or more drinks per day and/or drinking five or more drinks at any one time in the previous month) compared with a national median of 11.5% (range=3.6%-21.0%).⁵ Approximately 250 to 800 children are born with fetal alcohol syndrome (FAS) or fetal alcohol effect (FAE) in Minnesota each year.⁶⁻⁸ In 1991 alone, the economic cost of FAS to Minnesota was more than \$44 million.⁹

As a highly credible source of information for their patients, primary care providers are in a good position to promote alcohol-free pregnancy. The American Medical Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and other professional medical associations have passed policy statements recommending a consistent message of abstinence to all pregnant women.¹⁰ In addition, the Institute of Medicine has determined that screening and counseling for alcohol use during prenatal care is "the most important approach to universal prevention."¹² Nonetheless, systematic

screening and counseling for behavioral and social risks during pregnancy are limited, particularly for alcohol use.¹¹⁻¹⁴ Recent studies have found large discrepancies between physician intentions, physician practice, patient expectations, and published guidelines.¹⁵

Many factors influence primary care providers' preventive practices. Green et al.¹⁶ propose a conceptual framework of predisposing, enabling, and reinforcing factors that influence preventive practices in the health care setting (see Table 1). Interventions focusing on these factors can significantly increase the frequency and quality of screening and counseling, thereby contributing to subsequent health behavior changes in patients.¹⁷⁻¹⁹

This study was designed to answer three primary questions: 1) What experiences and perceptions are reported by a sample of Minnesota health care providers regarding screening pregnant women for alcohol use? 2) What barriers and benefits to systematic screening, counseling, and referral are identified by these providers? 3) To what extent, and in what format, do these providers desire continuing education related to the epidemiology of FAS and/or screening and counseling for alcohol use during pregnancy? This study also addressed screening children for fetal alcohol exposure. Very few providers reported any experience screening children for FAS or FAE, although this report does not describe these findings in more detail.

METHODS

The qualitative descriptive study involved focus groups, key informant interviews, and respondents' comments on a draft report outlining study findings and implications.

Table 1

Factors that influence screening and counseling practices of primary care providers*

Predisposing factors are intrinsic characteristics of individuals or populations that provide rationale or motivation for screening and counseling.

- Knowledge and awareness
- Attitudes and values
- Beliefs
- Self-efficacy
- Personal health behavior
- Existing skills

Enabling factors are characteristics of the environment that facilitate screening and counseling or acquisition of skills and resources to conduct screening and counseling.

- Adequate reimbursement mechanism
- Adequate staff time
- Clear practice guidelines
- Validated screening instrument
- Skills-building opportunity

Reinforcing factors represent continuing incentive to sustain preventive screening and counseling practices over time.

- Peer support
- System support
- Positive feedback from patients
- Observed changes in patient behavior
- Enhanced self-efficacy in fulfilling the role of healer

*Adapted from Green, Eriksen, and Schor, 1988.¹⁶

socioeconomic status. Discussions were recorded on audiotape for subsequent transcription and review.

At the close of each focus group, participants were asked to identify one or more colleagues in Minnesota who could offer researchers unique knowledge and/or experience. Of the 41 key informants subsequently identified, all agreed to a 15-minute telephone (n=38) or in-person (n=3) interview. Most key informants (65%) were practicing health care providers representing medicine and nursing. Additional informants represented public health, education, and community-based organizations. We sent a draft report outlining key findings and preliminary recommendations with an invitation to review and comment to all key informants and focus group participants with a known address (n=94, 85%). Nineteen feedback questionnaires (20%) were returned.

Because of scheduling and time constraints, some focus groups were conducted with group practices during regularly scheduled staff meetings. Though familiarity may have contributed to response bias, this format enabled facilitators to observe how some established medical practices address this issue. Many participants were recruited through the Minnesota Council of Preventive Medicine; members of this council may be relatively more supportive and experienced in preventive practice, so their responses are likely to bias the results.

RESULTS

Providers perceive many barriers to screening (see Table 2). Although most said they routinely discuss alcohol use during the first prenatal visit, responses indicated that the nature and extent of screening and counseling, as well as providers' self-confidence and comfort, are widely variable. Personal factors that inhibit routine screening and counseling include: 1) uncertainty regarding the epidemiology of FAS and the "best" medical recommendation about alcohol use during pregnancy; 2) limited confidence in screening skills and the ability to obtain an accurate patient history; 3) concern that some

Trained physician-facilitators convened eight one-hour focus groups intended to stimulate discussion and reflection on personal experience, individual beliefs, and clinical practices related to alcohol use and pregnancy. Of 71 participants, nearly 40% (n=28) were physicians. Overall, the participants represented a range of disciplines and specialties,

including family practice (n=16), pediatrics (n=8), obstetrics and gynecology (n=3), internal medicine (n=1), nursing (n=24), midwifery (n=9), medical assistants (n=4), social work (n=4), and health education (n=2). The number of participants per group ranged from four to 18. Groups were held in urban and rural clinics, which serve clients of different races and

Table 2

*Prenatal screening and counseling for alcohol use: Influencing factors and potential implications***KEY FINDINGS****IMPLICATIONS****Predisposing factors***Knowledge and awareness*

Providers overwhelmingly agreed that alcohol use can endanger the fetus, but were uncertain of many specifics, such as the:

- Level of risk associated with different levels of alcohol use,
- Scope of the problem,
- Best time during pregnancy to screen,
- Best medical recommendation.

Providers need a primer on the state of the science.

State-specific data on the prevalence and incidence of FAS and alcohol use during pregnancy are needed to illustrate the scope of the problem to many providers.

Beliefs

Providers believed:

- They have a role in prevention.
- It is difficult to obtain an accurate history.
- Patients may abandon prenatal care if asked about alcohol use.

Efforts should build on existing and emerging interest in prevention and affirm an interdisciplinary, team approach.

Screening for alcohol use should be viewed in the broader context of screening for other important behavioral and social risks (other drug use, violence).

The clinical importance of screening and counseling should be emphasized. Build nonjudgmental screening skills to maximize trust and rapport.

Attitudes, existing skills, and self-efficacy

Providers expressed personal discomfort and limited confidence in ability to screen.

Providers generally indicated a lack of experience helping patients deal with alcohol-related problems.

Providers need opportunities to assess their values and beliefs concerning alcohol use, and opportunities to practice and receive feedback on screening techniques.

Providers should be briefed on planned responses to different drinking patterns.

Some health care providers have unresolved personal attitudes related to alcohol use. These attitudes may affect interactions with patients.

Enabling factors*Adequate staff time*

Staff time for screening and counseling is limited.

Brief validated screening tools are available and need to be more broadly disseminated. Training opportunities should accompany this dissemination.

Validated screening instrument

Providers desire validated screening tools (and training in their use).

Reinforcing factors*Peer support*

There is not a clear professional expectation concerning screening and counseling for alcohol use.

Medical implications of alcohol use and clinical implications of screening need to be more formally stated in practice guidelines.

System support

Providers questioned whether adequate treatment services were available and described poor communication with referral sites.

Providers need opportunities to receive feedback from patients and referral sites regarding treatment outcomes.

patients may forgo prenatal care because of a reluctance to answer questions about alcohol use; and 4) unresolved personal issues concerning alcohol use.

Lack of time emerged as a leading system-level barrier to more routine screening and counseling. In addition, the perceived lack of a validated screening instrument; lack of clear, science-based counseling guidelines; and limited peer and system support were repeatedly cited as major barriers. Given uncertainty about the availability and effectiveness of referral networks and alcohol treatment programs, many providers said they view screening as pointless.

When asked about their desire for continuing education related to the epidemiology of FAS and/or screening and counseling for alcohol use during pregnancy, providers overwhelmingly indicated that their medical schools and residency programs inadequately prepared them in these areas. Most expressed a need and desire for practical information relevant to their clinical practices. They identified the following as possible educational opportunities:

- workshops and seminars for academic credit and/or professional continuing education;
- targeted newsletters, pamphlets, and other correspondence with health care providers;
- grand rounds;
- home and self-study courses;
- training videos that model counseling techniques; and
- professional conferences.

However, a minority of respondents said educational opportunities should not be offered. For example, one provider commented, "There is a lot of training right now. I don't know if there is any need for expensive, extensive education programs. I would rather see money spent in better areas like high school education—more grassroots. Spending money on us is spending it on the wrong group."

DISCUSSION

Performing comprehensive, universal screening and counseling to promote alcohol-free pregnancy was not the norm among the interviewed providers, who identified many of

the same screening barriers reported elsewhere.¹¹ Findings support previous research suggesting that providers are more likely to screen and counsel patients if they believe and perceive consensus around medical recommendations and are confident in their own knowledge and skills.²⁰

The implications of these findings are presented in Table 2. The most pressing educational recommendations are to 1) present providers with a primer on the "state of the science" of how alcohol affects the fetus; 2) present data to counter beliefs and attitudes that inhibit screening and counseling; 3) disseminate brief, validated screening tools^{10,21} and messages to use during counseling; and 4) provide practical skills-building opportunities to screen and counsel for alcohol use during pregnancy. Providers expressed a need and desire for continuing education and suggested options.

Beyond identifying continuing education needs for individual medical providers, these findings also have implications for clinic structure and support systems. The systems barriers clinicians face are real and need to be addressed. Even with new information, skills, and tools, providers still need more time, more evidence of patient behavior changes resulting from their advice, more confidence in the referral, treatment, and available support for patients with chemical dependency, and more clinic structures that enable and reinforce screening.

Prevailing community drinking norms and public policies also shape provider attitudes regarding screening and counseling pregnant women for alcohol use. Minnesota providers are mandated by law to report patients suspected of illicit drug use during pregnancy, but *not* alcohol and tobacco use. During some focus groups and interviews, providers argued that this policy reinforces a casual attitude toward legal drugs, though providers did not necessarily want to report pregnant patients who use alcohol and tobacco. Arguably, this law reflects the widespread view of alcohol as primarily a beverage, and secondarily a drug. Given the broader social context, it is not so

surprising that comprehensive screening and counseling for alcohol use as a behavioral risk is limited for all patients, pregnant or otherwise.^{20,22}

To achieve state²³ and national²⁴ public health goals to reduce the incidence of fetal alcohol exposure, immediate action is needed to increase health care providers' knowledge and skills; to refine, implement, and evaluate screening tools and clinical practice guidelines; remedy systems that isolate primary care providers from community resources and treatment services; strengthen incentives to screen and counsel for alcohol use; and integrate preventive practices regarding alcohol use with other behavioral risks.

To reduce alcohol-related birth defects, these health care initiatives should be coordinated with primary prevention programs, such as a two-year statewide broadcast media campaign currently underway to promote alcohol-free pregnancy.²⁵ Through near universal participation of commercial television and radio stations in Minnesota, more than 79,000 radio commercials and more than 6,000 television commercials have been broadcast.* Furthermore, FAS prevention should be conceptualized as one element of a broader campaign urgently needed to address a wide array of alcohol-related problems facing Minnesota, including alcohol-related violence, unintended injury, and chronic disease.⁹ **MM**

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REFERENCES

1. Bloss G. The economic cost of FAS. *Alcohol Health Res World* 1994;18:53-4.
2. Stratton K, Howe C, Battaglia F, eds. *Fetal alcohol syndrome: diagnosis, epidemiology, prevention, and treatment*. Washington, D.C.: National Academy Press, 1996.
3. Streissguth AP. A long-term perspective of FAS. *Alcohol Health Res World* 1994;18:74-81.
4. Bonthius DJ, West JR. Alcohol-induced neuronal loss in developing rats: increased brain damage with binge exposure. *Alcohol Clin Exp Res* 1990;14:107-18.
5. Centers for Disease Control and Prevention. Frequent alcohol consumption among women of childbearing age—Behavioral Risk Factor Surveillance System, 1991. *MMWR* 1994; 43:328-9,335.
6. Abel EL, Sokol RJ. Incidence of fetal alcohol syndrome and economic impact of FAS-related anomalies. *Drug Alcohol Depend* 1987;19:51-70.
7. Abel EL, Sokol RJ. A revised conservative estimate of the incidence of FAS and its economic impact. *Alcohol Clin Exp Res* 1991; 15:514-24.
8. Minnesota Department of Human Services. Research news: alcohol and drug use during pregnancy. St. Paul, Minnesota: Department of Human Services, 1993.
9. Minnesota Department of Health. Alcohol use in Minnesota: extent and cost. Minneapolis: Minnesota Department of Health, 1995.
10. U.S. Preventive Services Task Force. *Guide to clinical preventive services*. 2nd ed. Baltimore: Williams & Wilkins, 1996.
11. Donovan CL. Factors predisposing, enabling and reinforcing routine screening of patients for preventing fetal alcohol syndrome: a survey of New Jersey physicians. *J Drug Educ* 1991;21:35-42.
12. Kogan MD, Kotelchuck M, Alexander GR, Johnson WE. Racial disparities in reported prenatal care advice from health care providers. *Public Health Rep* 1994;84:82-8.
13. Peterson PL, Lowe JB. Preventing fetal alcohol exposure: a cognitive behavioral approach. *Int J Addict* 1992;27:613-26.
14. Mueller DP. Alcohol, tobacco and pregnancy: the beliefs and practices of Minnesota women. Minneapolis: Minnesota Department of Health FAS/FAE Prevention Program (prepared by Amherst H. Wilder Foundation, Wilder Research Center), 1994.
15. Green LW, Kreuter MW. *Health promotion planning: an educational and environmental approach*. 2nd ed. Mountain View, California: Mayfield, 1991.
16. Green LW, Eriksen MP, Schor EL. Preventive practices by physicians: behavioral determinants and potential interventions. *Am J Prev Med* 1988;4:S101-7.
17. Buchsbaum DG, Buchanan RG, Lawton MJ, Elswick RK. A program of screening and prompting improves short-term physician counseling of dependent and nondependent harmful drinkers. *Arch Intern Med* 1993;153: 1573-7.
18. Johns MB, Hovell MF, Drastal CA, Lamke C, Patrick K. Promoting prevention services in primary care: a controlled trial. *Am J Prev Med* 1992;8:135-40.
19. Terry P, Pheley A, Williams D, Strickland S. The result of an educational intervention for physicians providing HIV-antibody testing and counseling. *Minn Med* 1992;75:37-9.
20. Bradley KA, Curry SJ, Koepsell TD, Larson EB. Primary and secondary prevention of alcohol problems: U.S. internist attitudes and practices. *J Gen Intern Med* 1995;10:67-72.
21. U.S. Department of Health and Human Services. *Maternal substance use assessment methods reference manual: a review of screening and clinical assessment instruments for examining maternal use of alcohol, tobacco, and other drugs*. Rockville, Maryland: U.S. Department of Health and Human Services, 1993; Publication number (DHHS) SMA93-2059; CSAP Special Report No. 13.
22. Dever J, Kalsbeek W, Sanders L, et al. *Counseling practices of primary-care physicians—North Carolina, 1991*. *MMWR* 1991;41:565-8.
23. Minnesota Department of Health. *Minnesota public health goals*. Minneapolis: Minnesota Department of Health, 1995.
24. U.S. Department of Health and Human Services. *Healthy People 2000: national health promotion and disease prevention objectives*. Washington, D.C.: United States Government Printing Office, 1990. DHHS Pub. No. PHS 91-50212.
25. Miner KJ, Kingsbury L, Gentling G, Bishop D. Promoting alcohol-free pregnancy in Minnesota: a case study in social marketing. *Social Marketing Quarterly* 1995;2:6-9.

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Alcohol Use During Pregnancy

How Health Care Providers Can Make a Difference

Communities and health care providers need to address alcohol use before and during pregnancy—a public health problem tied to a variety of social and health risk factors.

Richard C. Lussky, M.D.

The preceding article by Dr. Kim Miner and colleagues (page 43) addresses an important public health issue: the barriers health care professionals face when screening and counseling women about their alcohol use during pregnancy. Their report makes it clear that alcohol use involves entire families and is frequently linked to other behavioral, medical, and socioeconomic risk factors—observations I have often made as a practicing neonatologist.

Pregnancy provides a patient and her physician an opportunity to improve the woman's health and that of her family.¹ Drug use during pregnancy is a significant public health problem today. Recent studies have shown that 10 percent to 15 percent of women use alcohol or other drugs during pregnancy.² The 1990 Household Survey on Drug Abuse sponsored by the National Institute on Drug Abuse found that of the 60 million U.S. women of childbearing age, 30.5 million (50.8 percent) consumed alcohol in the past month.³ In Minnesota, over 18 percent of women aged 18 to 44 report frequent drinking.*⁴

Drug use is frequently misperceived as a problem of the inner city, minority populations, and the poor, when, in fact, alcohol and drug use occurs in all our communities and among pregnant women of all social strata. Extensive literature supports this. For example, one study showed no difference in the rate of drug use between clinic and private patients, or between black and white patients.⁵

It is important to be aware that drug use during pregnancy may be associated with a history of low-birthweight or premature infants, spontaneous abortion, limited prenatal care, family dysfunction, and such conditions as hepatitis, malnutrition, endocarditis, and psychiatric disorders.⁶ There is no defined safe level of alcohol intake during pregnancy. One study found an

increased risk of giving birth to an infant with fetal alcohol effect (FAE) with as little alcohol consumption as 0.84 drinks per day.⁷ Other studies have shown that ingestion of one ounce of absolute alcohol per day increases the risk of FAE.^{8,9} This is the amount of alcohol in one to two standard drinks; a glass of wine, a can of beer, and a mixed drink all contain about the same amount of alcohol. The American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, and the Surgeon General all strongly recommend abstinence during pregnancy,¹⁰ and research supports this recommendation.^{11,12} Since the basic elements of the central nervous system are formed by four weeks after conception,¹³ it is critical that women adopt healthy behaviors before they become pregnant and that all women be screened for alcohol and drug use during their initial preconception or prenatal health care visits.

The problems related to drug use during pregnancy are complicated by the fact that drug use is often linked to other risk factors, as Miner and her colleagues point out. Use of one drug frequently leads a person to use and abuse other drugs. Women who use drugs also experience a significantly higher rate of abuse (physical, sexual, and emotional) at the hands of their partners. Underutilization of health care services, characteristic of drug- and alcohol-abusing patients, may make it difficult for health care providers to identify other associated medical problems—such as sexually transmitted diseases, including hepatitis and AIDS—further jeopardizing the health of the patient and her family. These women also tend to experience more family dysfunction and have less social support. If physicians are unaware of these important associations, they risk treating recurring symptoms without ever addressing the underlying causes.

Many health care professionals are concerned that patients may avoid seeking health care if they feel threatened or challenged by a practitioner who asks about drug use. I believe health care is a partnership between patients and physicians and that it is our duty to work with patients to optimize their health. I ask about drug use and its ties to other risk factors and assess the impact it has

*The Centers for Disease Control and Prevention defines frequent drinking as 30 or more drinks in the immediate past month or five or more drinks on one occasion in the past month.

on my patients and their families. I try to be empathetic, respectful, and nonjudgmental in my approach. I have learned that the chances of a successful intervention are far better if patients believe I have a sincere interest in improving their health. Studies have repeatedly shown that the advice women receive from physicians and other health care professionals is the most important factor in their decision to decrease their alcohol consumption.¹⁴ Health care professionals need to be aware that the attitude they convey on this subject can significantly affect the quality of their communication with patients and the effectiveness of therapeutic interventions.

The frustratingly limited time physicians can devote to individual patients demands that we use an efficient and integrated approach to preventive medicine that includes an assessment for drug use and domestic violence and questions about health care access and utilization. A routine, integrated screening approach to alcohol use during pregnancy, along with patient education and treatment, decreases alcohol consumption and improves pregnancy outcome and the health of the woman and her infant.¹⁵⁻¹⁹ Validated screening tools for alcohol use are available to the clinician,^{6,20,21} who can incorporate screening questions into the standard history-taking at the patient's initial preconception or prenatal office visits.⁶ A procedure is available for ascertaining the amount of alcohol consumed around the time of conception and prenatally; it has good reliability and a solid predictive validity for the occurrence of alcohol-related birth defects.²²

Miner and her co-authors make the point that the medical community, policymakers, and society must have data to justify public health expenditures in today's era of intense competition for medical care dollars. If screening for maternal alcohol use is done routinely and uniformly, these data will be available to determine the effectiveness of interventions. The American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, and the American Academy of Family Physicians are providing needed leadership by developing and disseminating practice guidelines, including screening tools and counseling recommendations, and promoting graduate and postgraduate education in these areas. Screening must be complemented by greater availability of community-based treatment programs that meet the special needs of pregnant women and their children.

The topic of alcohol use during pregnancy usually focuses on a woman's behavior, but it is important for health care professionals to also consider the medical status, health behaviors, and influence of the pregnant patient's partner, who often plays a significant role in shaping the woman's health-related behaviors, including drug use.

Research suggests paternal alcohol use may directly affect children, as well. In a recent literature review of the effect on offspring of paternal exposure to alcohol,²³ Dr. Theodore Cicero found that in humans: 1) alcoholism appears to be genetically linked with the father;^{24,25} 2) paternal alcohol use is tied to impaired cognitive skills

and hyperactivity in children (a few reports cited fetal alcohol syndrome in children born to alcoholic fathers when there was no evidence of heavy alcohol consumption by the mother during pregnancy);²⁶⁻²⁸ 3) paternal, preconception alcohol use can produce adverse effects in children;²³ and 4) abnormalities can occur in the sperm and semen of men using alcohol.^{29,30}

Neonatologists see far too many fragile patients paying the price of maternal and paternal drug and alcohol use. Health care providers need to work within their communities to end the problem of prenatal drug exposure, including fetal alcohol syndrome and fetal alcohol effect. I'll describe two programs I've worked with, although the opportunities are many. The March of Dimes, whose mission is to "improve the health of babies by preventing birth defects and infant death," has established a "CAREs" approach that incorporates community programs, advocacy, support of medical research, and education of the community. Emily Gunderson, director of Community Services for the March of Dimes, can be reached at 612/835-3033. Minnesota Healthy Roots is a multiprofessional and community volunteer organization whose mission is to prevent the effects of alcohol and other drugs on the health of mothers and their babies and to support families that have been affected by perinatal substance abuse. The organization has individual work groups on professional education, legislative/public policy, and public awareness. Joyce Holl, program manager, can be reached at 612/647-6905.

I would like to challenge my colleagues across the state to increase their work in our communities on behalf of all our patients.

MM

Richard Lussky is a neonatologist and assistant medical director of the Newborn Intensive Care Unit at Hennepin County Medical Center and a member of the Minnesota Medicine Advisory Committee.

REFERENCES

1. Weiner L, Rosett HL, Mason EA. Training professionals to identify and treat pregnant women who drink heavily. *Alcohol Health Res World* 1985;10:32-5,70-1,74.
2. Silverman S. Scope, specifics of maternal drug use, effects on fetus are beginning to emerge from studies. *JAMA* 1989;261:1688-9.
3. Khalsa JH, Gfroerer J. Epidemiology and consequences of drug abuse among pregnant women. *Semin Perinatol* 1991;15:265-70.
4. Centers for Disease Control and Prevention. Frequent alcohol consumption among women of child-bearing age. *MMWR* 1994;43:328-9,335.
5. Chasnoff I, Landress H, Barrett M. The prevalence of illicit drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *N Engl J Med* 1990;322:1202-6.
6. Hinderliter SA, Zelenak JP. A simple method to identify alcohol and other drug use in pregnant adults in a prenatal setting. *J Perinatol* 1993;13:93-102.
7. Jones KL. Diagnosis and management of fetal alcohol syndrome. *Pediatric Rounds* 1991:5-8.
8. Hanson JW, Streissguth AP, Smith DW. The effects of moderate

alcohol consumption during pregnancy on fetal growth and morphogenesis. *J Pediatr* 1978;92:457-60.

9. Little RE. Moderate alcohol use during pregnancy and decreased infant birth weight. *Am J Public Health* 1977;67:1154-6.

10. United States Public Health Service. Surgeon General's advisory on alcohol and pregnancy. *FDA Drug Bull* 1981;11:9-10.

11. Day NL. The effects of prenatal exposure to alcohol. *Alcohol Health Res World* 1992;16:238-44.

12. Blume SB. Chemical dependency in women: important issues. *Am J Drug Alcohol Abuse* 1990;16:138-48.

13. Moore KL. The nervous system. In: *The developing human*. 2nd ed. Philadelphia: W.B. Saunders, 1977:327-58.

14. Minor M, VanDort B. Prevention research on the teratogenic effects of alcohol. *Prev Med* 1982;11:346-59.

15. Little RE, Streissguth AP, Guzinski GM, et al. An evaluation of the pregnancy and health program. *Alcohol Health Res World* 1985;10:44-53,71,75.

16. Little RE, Young A, Streissguth A, et al. Preventing fetal alcohol effects: effectiveness of a demonstration project. In: *Mechanisms of alcohol damage in utero: Ciba Foundation Symposium 105*. London, England: Pitman Publishing, 1984.

17. Rosett HL, Weiner L, Lee A, et al. Patterns of alcohol consumption and fetal development. *Obstet Gynecol* 1983;61:539-46.

18. Larsson G. Prevention of fetal alcohol effects: an antenatal program for early detection of pregnancies at risk. *Acta Obstet Gynecol Scand* 1983;62:171-8.

19. Russell M, Bigler L. Screening for alcohol-related problems in an outpatient obstetric-gynecologic clinic. *Am J Obstet Gynecol* 1979;134:4-12.

20. Hankin JR, Sokol RJ. Identification and care of problems

associated with alcohol ingestion in pregnancy. *Semin Perinatol* 1995;19:286-92.

21. Rosett HL, Weiner L, Edelin K. Treatment experience with pregnant problem drinkers. *JAMA* 1983;249:2029-33.

22. Sokol RJ, Miller SI, Debanne S, et al. The Cleveland NIAAA prospective alcohol-in-pregnancy study: the first year. *Neurobehav Toxicol Teratol* 1981;3:203-9.

23. Cicero TJ. Effects of paternal exposure to alcohol on offspring development. *Alcohol Health Res World* 1994;18:37-41.

24. Merikangas KR. The genetic epidemiology of alcoholism. *Psychol Med* 1990;20:11-22.

25. Pickens RW, Svikiel DS, McGue M. Heterogeneity in the inheritance of alcoholism. *Arch Gen Psychiatry* 1991;48:19-28.

26. Scheiner AP, Donovan CM, Bartoshesky LE. Fetal alcohol syndrome in child whose parents have stopped drinking. *Lancet* 1979;1(8125):1077-8.

27. Henderson GI, Patwardhan RV, Joyumpa AM, et al. Fetal alcohol syndrome: overview of pathogenesis. *Neurobehav Toxicol Teratol* 1981;3:73-80.

28. Randall CL, Noble EP. Alcohol abuse and fetal growth in development. In: Mello NK, ed. *Advances in substance abuse*. Vol. 1. Greenwich, Connecticut: JAI Press, 1980:327-67.

29. Abel EL. Paternal exposure to alcohol. In: Sondereg TB, ed. *Perinatal substance abuse: research findings and clinical implications*. Baltimore: Johns Hopkins University Press, 1992:132-62.

30. Yazig RA, Odem RR, Polakoski KL. Demonstration of specific binding of cocaine to human spermatogenesis. *JAMA* 1991;266:1956-9.

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Fairview Position Changes: Rapp to Head Fairview-University Medical Center

Peter Rapp, general director of the University of Minnesota Hospital and Clinic, has been chosen to head the Fairview-University Medical Center, the new hospital that will be formed when University Hospital merges with Fairview Health System, expected to take place January 1. Rapp will be senior vice president and administrator of Fairview-University Medical Center.

As part of its reorganization, Fairview Health System has reassigned three Fairview senior vice presidents to new positions effective January 1.

Pam Tibbetts, currently senior vice president and administrator of Fairview Riverside Medical Center, will become senior vice president of clinical services integration. She will coordinate the integration of patient care services of Fairview and Fairview-affiliated health care providers.

Don Berglund, now senior vice president and administrator of Fairview Ridges Hospital in Burnsville, will become vice president and chief operating officer of Fairview-University Medical Center.

Mark Enger, senior vice president and administrator of Fairview Southdale in Edina, will become senior vice president and administrator of both Fairview Southdale and Fairview Ridges.

The four senior vice presidents will report to Bill Maxwell, Fairview's executive vice president and chief operating officer.

Charles Bolles Bolles-Rogers Award

The Hennepin Medical Society has chosen B.J. Kennedy, M.D., Regent's professor of medicine

emeritus and Masonic professor of oncology emeritus at the University of Minnesota, to receive this year's Charles Bolles Bolles-Rogers Award. The award recognizes his achievements in and contributions to medical research and his many years of leadership in the medical community.

Kennedy is considered one of the fathers of medical oncology. He developed the university's oncology program, which was the first of its kind in the world. "He has been an outstanding figure in oncology," said Marvin Goldberg, University Hospital chief of staff. "He is truly a pioneer, highly respected in and out of the field and around the world."

Blue Cross Executive Resigns

William Jenison has resigned as chief operating officer and group vice president at Blue Cross and Blue Shield of Minnesota. He also was senior vice president for Aware Integrated Inc., Blue Cross' holding company. He was the No. 2 executive, behind Chief Executive Officer Andy Czajkowski, who described Jenison's departure as "friendly." Jenison will act as a consultant to Blue Cross over the next several months.

Service to Humanity Award

United Hospital Foundation has honored David A. Rothenberger, M.D., and Doug Leatherdale with its 1996 Service to Humanity Award, which is given to individuals who have demonstrated selfless dedication and exemplary leadership in improving the health and welfare of the community of St. Paul and the surrounding areas.

Rothenberger is a colon and rectal surgeon recognized nationally for his service beyond the demands of patient care. He is

president of the American Society of Colon and Rectal Surgeons, serves on national committees in health care, and is a director/examiner for the American Board of Colon and Rectal Surgery.

Leatherdale is chair, president, and chief executive officer of the St. Paul Companies. He recently received the Humanitarian Award at the National Conference of Christians and Jews.

Health Care Coalition on Violence Director

The Health Care Coalition on Violence has hired Judi Ray as director to lead its efforts to reduce violence in Minnesota. The coalition was formed earlier this year as part of the Governor's Task Force on Violence as a Public Health Problem, chaired by David Strand, president of Medica Health Plans, Allina Health System. Its goal is to assemble a broad-based group to support anti-violence initiatives in the health care sector.

Most recently, Ray was administrator for the corporate and public affairs department at Minnetonka-based United HealthCare and, before that, she was business development coordinator for United HealthCare's public sector services.

Ray is the only paid staff person for the coalition. She is responsible for directing communication activities, including the development of resource materials, public presentations, and overall outreach efforts, as well as directing the office and maintaining the coalition budget.

Places

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MDH Launches Vaccination Campaign

The Minnesota Department of Health has started a campaign that

includes a 30-second TV spot to educate people about the need to obtain vaccinations throughout life. Federal officials have warned that thousands of American adolescents are at risk of contracting varicella, measles, and other diseases because they have not received vaccinations or booster shots.

For example, although most children get the measles vaccination as infants, many have not received the booster shot. By August 9 of this year, 350 cases of measles had been reported in the United States, a 38 percent increase over the same period in 1995, according to the Centers for Disease Control and Prevention. More than 70 percent of those afflicted were people over age 10 who either had not been immunized or who had received only a single shot, said Mayo Clinic's Gregory Poland, M.D., in a recent *St. Paul Pioneer Press* article.

**New Hennepin Clinic
Opens in Richfield**

Hennepin Care South Clinic, a new community clinic affiliated with Hennepin County Medical Center, opened September 23 at 44 West 66th Street in Richfield. Health care services include primary care and health maintenance for infants, children, adults, and seniors; acute care; well-women and well-child care; routine physicals for school, sports, camp, or work; speech language pathology; subspecialty referrals; health education; prenatal care; and mental health care. The clinic will provide laboratory services and on-site x-ray, mammography, and ultrasound. Dentistry will be offered starting in mid-October.

Socioeconomics
.....

**Delta Dental Administering
Medica Dental Plans**

Delta Dental will begin administering dental benefits for Medica Health Plans in January. Medica's

current contract is with Minnetonka-based United HealthCare Corp., but United plans to drop its dental program by the end of this year.

Medica's president, David Strand, predicts costs might go down because of Delta's efficient services. Delta, an affiliate of Eagan-based Blue Cross and Blue Shield of Minnesota, administers dental benefits for about 1.4 million people.

**Allina Acquires Nine Clinics from
United Behavioral Systems**

Allina Health System has acquired nine clinics from United Behavioral Systems-Minnesota, a business unit of United HealthCare that provides mental health and substance abuse services to about 3 million health plan members nationwide. The nine clinics are located in the Twin Cities metropolitan area. Allina's intent is to consolidate the delivery of mental health and substance abuse services within Allina Health System.

The 175-plus employees at the clinics will become Allina employees under Allina's Behavioral Health Services. United Behavioral Systems will continue to provide management services and consultation to Allina for Medica patients.


**Target Stores Alone in Plan
to End Tobacco Sales**

After Target stores decided to no longer sell tobacco products at its 714 stores nationwide, retailers Kmart and Wal-Mart said they have no immediate plans to follow suit. Dayton Hudson-owned Target decided revenues do not justify the problems involved with selling tobacco, such as preventing theft and sales to minors, according to Target spokesperson Susan Eich. She said sales account for less than half a percent of Target's annual revenues of \$15.8 billion.

Target stopped restocking stores with cigarettes in August, and it predicted stores would be

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out of stock by the end of September. The stores plan to expand sales of sports trading cards and convenience snack foods in place of cigarettes.

**UHC Paying \$100 Million to
MetraHealth's Former Shareholders**

Following Minnetonka-based United HealthCare Corp.'s purchase of MetraHealth, UHC is paying the company's former shareholders an earnings performance payment of \$100 million. Under the purchase agreement, UHC could have paid up to \$350 million if MetraHealth's operations had met all of its earnings performance goals. UHC already paid \$1.59 billion to Travelers and Metropolitan Life insurance companies for MetraHealth a year ago. UHC also may pay an additional \$175 million under the purchase agreement if United's net income for 1996 and 1997 reaches undisclosed levels.

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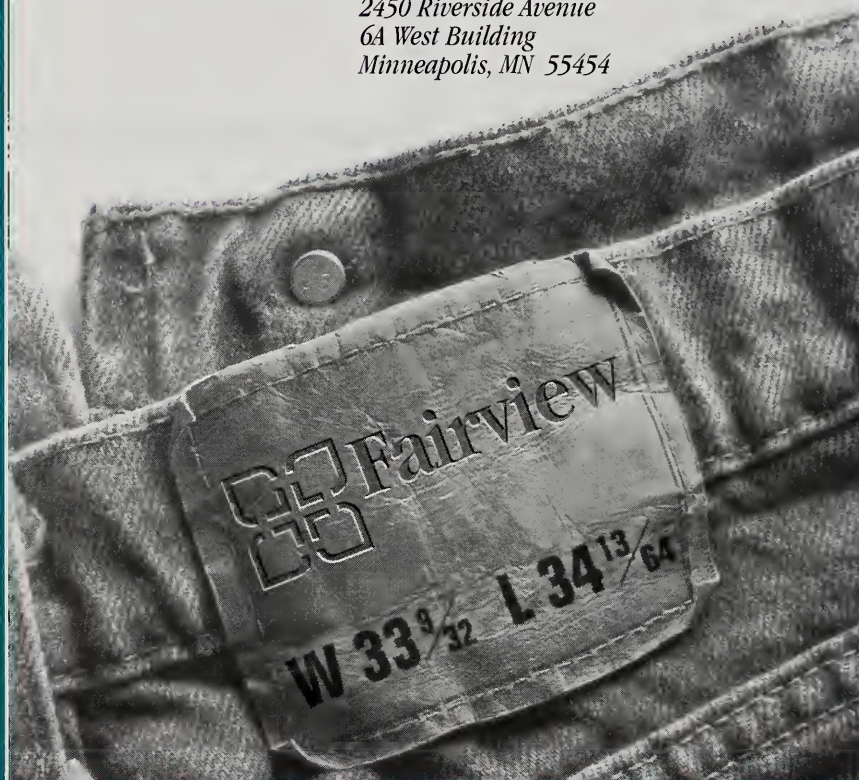
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"When we purchased Metra-Health, we wanted the purchase price to be tied to 1995 financial performance," said William McGuire, United chief executive, in a Twin Cities-based *Star Tribune*

article. "We believe that the mechanism we used for determining the amount of the earnout was well calibrated so that both United HealthCare and the sellers were satisfied."

State Votes to Keep Investments in Tobacco

The Minnesota Board of Investment rejected a proposal in September to stop investing state funds, including state employees' pension funds, in tobacco stocks. Secretary of State Joan Grove made the proposal because of concern over potential financial risk from recent lawsuits against tobacco companies and new federal efforts to regulate tobacco. She had suggested no new investments in six specific tobacco companies or in any companies that get 50 percent or more of their revenue from tobacco products.

The proposal failed on a 2-2 vote, with Attorney General Hubert H. Humphrey III abstaining because of his role in a lawsuit filed by the state and Blue Cross and Blue Shield of Minnesota against the tobacco industry. Grove and State Treasurer Michael McGrath voted for the change, and Gov. Arne Carlson and State Auditor Judi Dutcher voted against it.

Gov. Carlson argued that the board needs more information on the volatility of tobacco stocks before deciding not to invest in them. He has asked the board's executive director, Howard Bicker, to prepare an analysis of the stock's long-term performance prospects. "I might be willing to reconsider my vote," he said in a Twin Cities-based *Star Tribune* article.

The state controls assets valued at \$31 billion, of which \$25 billion is in public employees' pension funds. About \$320 million of the pension funds is invested in stocks of tobacco companies, 81 percent of which are involved in lawsuits.

Rates, Trends, Data

Teen Drug Use Up

Drug use among teens increased drastically between 1992 and 1995, according to the National Household Survey on Drug Abuse by the U.S. Department of Health

and Human Services. Monthly use of marijuana, for example, rose 105 percent in those years. Between 1994 and 1995, youth drug use overall rose 24 percent and monthly marijuana use rose 37 percent. Among youths aged 12 to 17, 10.4 percent used illicit drugs on a monthly basis in 1995.

Monthly use of LSD and other hallucinogens increased 183 percent between 1992 and 1995 and 54 percent between 1994 and 1995. Monthly cocaine use increased 166 percent between 1994 and 1995.

Catherine Seward, executive director of Hazelden Center for Youth and Families in Plymouth, said in the Twin Cities-based *Star Tribune* that Minnesota has experienced similar increases in youth drug use.

'U' Study Finds Minnesota's Rate of Uninsured Holding Steady

The proportion of Minnesotans who do not have health insurance has held steady at 6 percent—the same as in 1990—in contrast to a rising national average of 15 percent, according to a University of Minnesota study of 11,500 Minnesotans.

The Minnesota Health Care Insurance and Access Survey, conducted by the university's Institute for Health Services Research, also found that compared with 1990:

- The number of Minnesotans who purchased individual health insurance policies dropped from 9 percent to 5 percent, while those covered by public policies increased from approximately 19 percent to 22 percent.

- Minority representation among the uninsured has increased.

- Among the continuously uninsured (those lacking insurance for at least the previous 12 months), the proportion of children dropped from approximately 28 percent to 16 percent. "This is great news," said Kathleen Call,

principal investigator and assistant professor in the university's Institute for Health Services Research. "It indicates the success of state programs targeting children."

- As in 1990, the uninsured are more likely to be male and single than are the insured. The uninsured also tend to be younger, less educated, and less affluent.

- Also as in 1990, many

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uninsured cited cost as the primary reason they have not purchased insurance of their own. Few reported that they do not want or need health insurance.

- Of the 4.1 percent of continuously uninsured Minnesotans, an estimated 50 percent were eligible for MinnesotaCare, although many did not know they were eligible or how to enroll.

Physicians' Salaries Falling

Physicians' earnings fell about 4 percent from 1993 to 1994 to an average income of \$187,000, according to a report published in the journal *Health Affairs* based on annual surveys by the American Medical Association. It's the first decrease since statistics were initially compiled in 1982. Income has risen an average of 6 percent annually, or 2.2 percent when accounting for inflation.

The study says managed care likely plays a role in the reduced salaries, as well as diminishing Medicare reimbursements, reduced Medicaid payments in many states, and the trend toward more doctors working in group practices, where they work fewer hours but make less money.

The survey found that earnings for doctors in specialties such as general surgery, psychiatry, and gynecology dropped the most, 5.3 percent, from an average of \$189,121 to \$179,072. Physicians in subspecialties within internal medicine, surgery, and pediatrics earned an average of \$243,828, down 5.1 percent from \$256,868. Hospital-based physicians, including those in anesthesiology, radiology, pathology, and emergency medicine, made an average of \$214,828, down 4.5 percent, from \$224,902. Primary care physicians' salaries dropped the least—1.7 percent—to an average of \$129,353.

Law & Policy

Minnesota Smokers Suing Tobacco Companies

A group of Minnesota smokers has filed a lawsuit in Ramsey County District Court against a number of tobacco companies, claiming the companies concealed the addictive nature of nicotine, manipulated nicotine levels to get them hooked, and aimed advertising at young people to addict them while young.

The suit asks for certification as a class action to include all cigarette smokers in the state who use products made by the companies. Similar class action suits have previously been filed against the tobacco industry in Alabama, California, Louisiana, New Mexico, New York, Ohio, and Pennsylvania.

The suit was filed on behalf of Vern Masepohl, a Minnesotan in his early 30s who began smoking at about age 11 and has missed a lot of work because of smoking-related illnesses, said attorney Randy Hopper of the Minneapolis law firm Zimmerman Reed.

Innovations

New 3M Inhaler Approved

The U.S. Food and Drug Administration has approved a new asthma metered-dose inhaler by Maplewood-based 3M that is the first to deliver albuterol without using chlorofluorocarbons (CFCs). 3M developed the inhaler in response to international efforts to phase out the use of CFCs, believed to harm the ozone layer.

"We're very excited about this new product," said Fran DuMelle, deputy managing director of the American Lung Association. "3M has found a way to balance the patients' needs with international environmental guidelines—and there's no compromise to the product."

Schering-Plough will market and distribute the inhaler in the United States under the brand

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

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name Proventil HFA on behalf of 3M's pharmaceutical division.

New Procedure Gives More Infertile Couples Chance of Parenthood

Reproductive Health Associates, P.A., cooperating with faculty from the University of Minnesota, achieved the first successful pregnancy in Minnesota to a couple in which the man's ejaculate did not contain any sperm. The procedure used is a breakthrough for many men who have been told they cannot father a child.

The pregnancy was achieved by testicular sperm extraction (TESE), a simple operative procedure. A small piece of testicular tissue, about the size of a kernel of corn, was surgically obtained from the patient's testicle. The sperm was then removed from the tissue and injected into 10 eggs retrieved from



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his wife's ovaries. Five of the 10 eggs fertilized and were placed in the wife's uterus. One of those fertilized eggs survived. At seven weeks (on August 12), the clinic's Jacques Stassart, M.D., confirmed the pregnancy with ultrasound and reconfirmed it on August 26.

The doctors at Reproductive Health Associates (RHA) and the University of Minnesota's urologist and male infertility specialist Jon Pryor, M.D., first began using TESE in March 1996. RHA is the first center in the Upper Midwest to announce a pregnancy with TESE.

About 10 percent of men who have infertility problems have no sperm in their ejaculates. About two-thirds of these men cannot be treated by reconstructive surgery or hormonal treatments. TESE will now be an option for these men. RHA's director, Hugh Hensleigh, Ph.D., predicts pregnancy rates

with TESE will be similar to those for other couples being treated for infertility by in vitro fertilization—about 30 percent to 40 percent pregnancy rate per IVF cycle.

'U' Researchers Develop New Treatment for Myeloid Leukemia

University of Minnesota Cancer Center researchers have developed a new therapeutic agent that attacks myeloid leukemia, according to a report in the August 15 issue of *Blood* by University of Minnesota authors Bruce Blazer, M.D., associate professor of pediatrics, Daniel Vallera, Ph.D., professor of therapeutic radiology, and graduate student Chung-Huang and their colleagues. Clinical trials could begin within a year.

Researchers fused interleukin 3 (IL3) with diphtheria toxin to create the therapeutic agent. IL3 travels through the bloodstream and attaches to cells that have IL3 receptors, such as myeloid leukemia cells. One molecule of diphtheria toxin will kill a cell. IL3 also attacks some healthy cells, but enough blood-forming stem cells survive to prevent irreparable harm to patients, said Blazer.

Currently, diphtheria toxin fused to the immune protein interleukin 2 is being used in clinical trials to treat other forms of leukemia. Before clinical trials with IL3 can begin, scientists must develop a process to produce the new agent and obtain necessary approvals.

Medical Research

Alendronate Can Prevent Bone Fractures in Women

The drug alendronate can help prevent bone fractures in women with osteoporosis who are at highest risk, according to results of a study conducted at the University of Minnesota and centers across

the nation. The three-year vertebral fracture study was part of the larger Fracture Intervention Trial (FIT) funded by Merck & Co. Inc., maker of the drug studied, Fosamax®.

The study followed a sample of 2,027 post-menopausal women between the ages of 55 and 80 with osteoporosis. Study participants had low bone density at the hip and at least one existing spinal fracture; 1,022 took Fosamax®, and 1,005 took a placebo. FIT, which was conducted to assess the safety and effectiveness of Fosamax® in preventing fractures, found that the drug reduced the incidence of new spinal and hip fractures by half.

In a new analysis of the study results, researcher Kristine Ensrud, staff physician at the Minneapolis Veterans Affairs Medical Center and assistant professor of medicine and epidemiology at the university, found that alendronate was equally effective in reducing the incidence of new spinal fractures in women considered to be at highest risk for fracture because of advancing age, history of previous fracture, or bone mineral density.

“Our results suggest that it may never be too late in life to prevent osteoporotic fracture,” Ensrud said. She presented her findings at the September 11 annual meeting of the American Society of Bone and Mineral Research in Seattle. MM

LIMITATIONS

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lation-based screening may strike some people as nihilistic, the inherent limitations of this approach apply to any test with less than absolute specificity. Certainly, there have been successes in this field. The introduction of the Pap smear has been accompanied by a remarkable decrease in the death rate associated with cervical cancer (although, as some people point out, this reduction began before the test was widely implemented). Other interventions have been less successful, however, such as using periodic chest x-rays and sputum cytology to screen for lung cancer in smokers. These screening techniques have resulted in detection of lung cancer at earlier stages than in controls, but at least six major studies over the past 40 years have failed to show a resultant improvement in lung cancer death rate among those screened.⁶

Unfortunately, little evidence from prospective studies is available today to help physicians determine the appropriateness of many new and popular tests such as PSA, CA-125, and others in screening asymptomatic patients. The NIH, addressing this deficiency, is currently funding a large prospective study of screening for prostate, lung, colon, and ovarian cancers,⁷ but the conclusions from this study are not expected for 12 to 14 years. Until that time, considering the significant limitations of screening unselected populations and the uncertain benefits from these interventions, it may behoove physicians to be conservative in their recommendations to patients. While it may be difficult to deny new but unproven screening tests to individual patients who request them, physicians should at least provide an informed consent discussion of not only the benefits of early detection, but also the likelihood of and risks associated with a false-positive result.

MM

Peter Benson is a pathologist with North Pathology Associates in Robbinsdale, Minnesota.

REFERENCES

1. Cebul RD, Beck JR. Biochemical profiles. Applications in ambulatory screening and preadmission testing of adults. *Ann Intern Med* 1987;106:403-13.
2. Hayward RSA, Steinberg EP, Ford DE, et al. Preventive care guidelines: 1991. *Ann Intern Med* 1991;114:758-83.
3. Einhorn N, Sjøvall K, Knapp RC, et al. Prospective evaluation of serum CA-125 levels for early detection of ovarian cancer. *Obstet Gynecol* 1992;80:14-8.
4. Jacobs IJ, Oram DH, Bast RC. Strategies for improving the specificity of screening for ovarian cancer with tumor-associated antigens CA-125, CA 15-3, and TAG 72.3. *Obstet Gynecol* 1992;80:396-9.
5. NIH Consensus Development Panel on Ovarian Cancer. Ovarian cancer: screening, treatment, and follow-up. *JAMA* 1995; 273:491-7.
6. Wolpaw DR. Early detection in lung cancer: case finding and screening. *Med Clin North Am* 1996;80:63-82.
7. Kramer BS, Gohagens, Prorok PC, et al. A National Cancer Institute sponsored screening trial for prostatic, lung, colorectal and ovarian cancers. *Cancer* 1993;71:589-93.

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IMPROVE

continued from page 9

Early in the program, a survey of patient attitudes revealed that many patients consider preventive services very important, says Alexis. And while there's a growing—and well-warranted—expectation among physicians that patients should take more responsibility for their health, the mountain of tasks and responsibilities overwhelming so many people's lives today means that keeping track of one's last tetanus shot or cholesterol test ranks rather low on the to-do list.

"People want to take better care of themselves, but they need the reminders that a good screening program provides," says Martinson.

Just as individuals can find it difficult to follow new regimens for health improvement, CHS staff found that implementing their program had its challenges, too. "Certainly we encountered barriers," says Martinson. "Time, money, and lack of technical resources were the main ones. It takes a lot of staff time to establish a team, gather data, define what should be done, and then develop, implement, and evaluate an action plan. While IMPROVE certainly helped us financially—they paid for staff training sessions and materials, for example—Dr. Alexis' time away from her practice, staff time for data collection, and team meetings all represented increased costs."

Martinson also points out that CHS, like other clinics, receives no additional reimbursement to cover the extra costs associated with pre-

ventive screenings and education, despite being pushed by managed care to practice preventive medicine.

"Reimbursement is still based upon treating the patient's primary complaint, but not for spending an extra 10 minutes telling someone why they should quit smoking or eat more

• Ask medical staff to create a set of clinic standards with which everyone can agree so the clinic is consistent with patients.

• Take a systemwide approach.

• Involve everyone who will be affected by the project—physicians, nurses, certified medical assistants, medical records personnel, and other clinic staff.

• Involve patients as much as possible—let them know what you're doing and why; reinforce the idea of prevention whenever and wherever you can in your clinic.

• Have appropriate educational materials easily available to patients, doctors, and nursing staff.

• Use nurses or medical assistants to collect the data and, if possible, use an electronic record-keeping system to track and notify patients.

Though CHS' role in the IMPROVE Project is technically over, physicians and clinic staff continue to use and refine the process they developed. Both Alexis and Martinson agree that IMPROVE's systemwide approach is the key to providing better preventive

care and to increasing awareness of preventive health among their patients—regardless of why they come to the clinic. "All our patients now know what to expect when they come in," says Martinson. "Likewise, our physicians know what is—or what should be—done for the patient and where to look in the chart for that information. We've all seen that we can do a better job delivering preventive services, and that's very encouraging."

MM

Joseph Moriarity is a free-lance writer living in Scandia, Minnesota.

Preventive Services Selected by the IMPROVE Project

Cancer Screening

1. Clinical breast exams for women over age 49;
2. Mammograms for women over age 49; and
3. Pap smears for women over age 19.

Cardiovascular Disease Prevention

4. Tobacco cessation support at every visit for users over age 19;
5. Blood pressure tests and management for people over age 19; and
6. Cholesterol tests and management for people over age 19.

Immunizations

7. Influenza immunization for people over age 64; and
8. Pneumococcus immunization for people over age 64.

healthily," he says. "I'm not certain the health plans and larger systems realize that it takes a major commitment in time, financial resources, and staff to do something like this well."

An additional barrier Martinson notes is CHS' lack of good computerized clinical systems to keep track of the data they collect—and to make it more easily accessible.

For clinics interested in improving preventive services, Martinson offers these suggestions:

• Be committed, and be prepared for a lot of work.

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

OCTOBER 1996

Oct. 6-11 **Laboratory Diagnosis of Fungal Infections** Mayo Medical Laboratories; Portland Marriott at Sable Oaks, South Portland, ME. CONTACT: Kathy Bates or Julie McAdams, Mayo Medical Laboratories, Office of Continuing Medical Education, Hilton 360, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Oct. 11 **Northwestern Pediatric Society 84th Annual Meeting** University of Minnesota—Continuing Medical Education; Sheraton Inn Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 11 **Ophthalmic Plastics Course** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Oct. 25 **Infectious Disease Update** Institute for Research and Education HealthSystem Minnesota; Park Nicollet Clinic, St. Louis Park, MN. CONTACT: Kari Haeger, Park Nicollet Clinic, 3800 Park Nicollet Blvd., St. Louis Park, MN 55416; 612/993-3527.

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

Videotapes: **Emerging Infectious Diseases** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Oct. 11-12 **Advanced Life Support in Obstetrics** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Oct. 11-12 **Nursing Home Medical Directors** University of Minnesota—Continuing Medical Education; Sheraton Inn Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 11-12 **Vascular Disease Conference** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 12 **Twentieth Annual Current Trends in Ophthalmology Symposium** Phillips Eye Institute; Phillips Eye Institute, Minneapolis, MN. CONTACT: Michelle Hemingway, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061.

Oct. 14-16 **1996 International Meeting on ANCA and ANCA-Related Diseases** Mayo Clinic and Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Kay Kenitz, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; 507/284-8399.

Oct. 17-18 **Obstetrics and Gynecology Annual Autumn Seminar** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 18-19 **Pediatrics for Family Physicians** University of Minnesota—Continuing Medical Education; Holiday Inn, Duluth, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 23-24 **Duluth Diabetes Conference** Duluth Clinic; Duluth, MN. CONTACT: Rockie Odberg, Medical Education Coordinator, 400 East Third Street, Fifth Avenue Building, Duluth, MN 55805.

Oct. 25-26 **Current Treatments in Myofascial Pain and Muscle Spasms** HealthEast St. Joseph's Hospital; Embassy Suites Hotel, St. Paul, MN. CONTACT: Annette Anderson, 1700 University Avenue West, St. Paul, MN 55104; 612/232-5104.

Oct. 25 **Management of Patients with Non-insulin Dependent Diabetes in the Primary Care Setting** University of Minnesota—Continuing Medical Education; Sheraton Inn Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue

SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 26 **Current Therapies in Otolaryngology** Mayo Foundation; Mayo Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 28-30 **Clinical Reviews 1996** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

N O V E M B E R 1 9 9 6

Nov. 1 **Cancer Center Symposium** University of Minnesota—Continuing Medical Education; Cancer Center, University of Minnesota, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 1 **Fifth Annual Conference for CME Planners** Minnesota Medical Association; Northland Inn, Brooklyn Park, MN. CONTACT: Jane Phillip, Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/999-1875.

Nov. 1-2 **End-of-Life Health Care in Managed Care Systems** University of Minnesota—Continuing Medical Education; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 2-6 **American Society of Nephrology 29th Annual Meeting and Scientific Exposition** University of Minnesota—Continuing Medical Education; New Orleans, LA. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 4 **Hot Topics in Hypertension/Satellite Meeting** University of Minnesota—Continuing Medical Education; New Orleans, LA. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 4-5 **Advanced Trauma Life Support** Allina Health System; United Hospital, St. Paul, MN. CONTACT: Annette Carlson, Allina Health System, 5601 Smetana Drive-80780, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3826.

Nov. 8 **E.T. Bell Pathology Symposium** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 9 **Milestones in Therapy for Congestive Heart Failure: What Have We Learned? (AHA Satellite)** University of Minnesota—Continuing Medical Education; New Orleans,

LA. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 9 **Minnesota Society of Pathologists Annual Fall Anatomic Pathology Conference With Steve Silverberg, M.D.** Minnesota Society of Pathologists; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Jennifer Nelson, MSP, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Nov. 9 **Minnesota Psychiatric Society Fall Scientific Conference** Minnesota Psychiatric Society; Doubletree Grand Hotel, Mall of America, Bloomington, MN. CONTACT: Carol Eshelman, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/623-2835.

Nov. 11-13 **Clinical Reviews 1996** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 13 **GI Update** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 14 **ICare** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

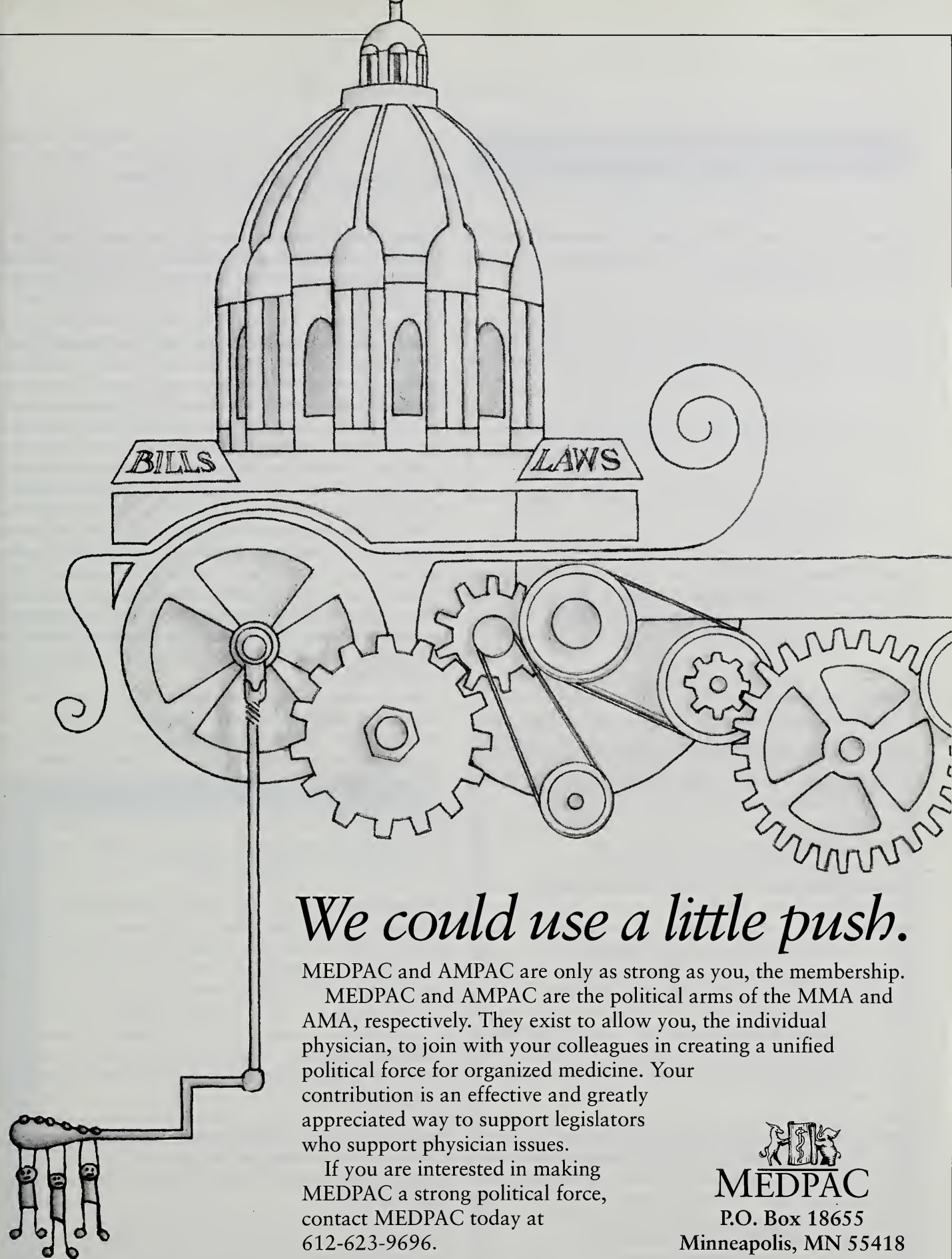
Nov. 14-16 **Mayo Clinic Ob/Gyn Clinical Reviews** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 21-23 **Home Care Medical Directors Training Seminar** University of Minnesota—Continuing Medical Education; Embassy Suites, Orlando, FL. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 22-23 **Gas Exchange and Pulmonary Function** University of Minnesota—Continuing Medical Education; Wyndham Anatole Hotel, Dallas, TX. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 22-23 **Tenth Primary Care Update** Institute for Research and Education HealthSystem Minnesota; Radisson Plymouth Conference Center, Plymouth, MN. CONTACT: Kari Haeger, 3800 Park Nicollet Boulevard, St. Louis Park, MN 55416; 612/993-3527.

Nov. 23 **Minnesota Society of Neurological Sciences Annual Meeting** Minnesota Society of Neurological Sciences; Radisson Plaza Hotel, Minneapolis, MN. CONTACT: Lisa Deminsky, 22732 132nd Avenue North, Rogers, MN 55374; 612/588-0661.



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A year ago, a peer support group for physicians with cancer was formed by the Hennepin Medical Society at the Virginia Piper Cancer Institute. Regular monthly meetings started in

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There is no charge for the group.

The group meets:

Second Thursday of each month

7 pm to 8 pm

Virginia Piper Cancer Institute

800 East 28th Street at Chicago Avenue
Minneapolis, Minnesota

If you have any questions about the group, contact Dick Sellers, facilitator, at 612/863-4000.

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Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS



SURFING THE INTERNET
A Physician Guide

NOVEMBER 1996



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Welcome to the Internet



.....
*"Electronics
 may help us
 send our
 words easier
 and farther,
 but do we
 have anything
 to say?"*

Penciled, typed, word processed. The descriptions we have for communicating with words say a lot. Penning evokes the image of Fitzgerald, creating prose that captures an era. Word processing sounds mechanical, more a product of a machine than a person. Has detachment replaced passion as carpal tunnel syndrome has unseated writer's cramp? Has the cyberworld turned Shakespeare's tongue into digital doublespeak? Electronics may help us send our words easier and farther, but do we have anything

to say? Like most revolutions, the computer simultaneously solves and creates problems. As our words and images reach around the globe, the Internet has the potential to crystallize or garble the message. What the superhighway revolution may do for and to medicine is covered in this month's *Minnesota Medicine*.

Find out what the Internet is and what's there for docs in this month's cover stories—a physician guide to the Internet (page 12) and a description of the MMA's new World Wide Web home page (page 20). Meet someone who was on the Internet long before it was chic in our profile of Paul Kleeberg, M.D. (page 8). Learn what the Internet may mean for the commerce of knowledge in our feature story on medical publishing (page 26). And decide if doctors are really hopeless technophobes in this month's clinical article on family practitioners learning the Web (page 43).

Each leap in the history of communication has remodeled the way we interact. The progression from speech to alphabet to printing press to telegraph to telephone to radio to television to satellite has jolted our consciousness at every stage. The Internet is the latest jolt, bringing the reality of the word "global" into our homes and offices. Since medicine is a science and art that

depends on communication and the adoption of new technology, physicians should embrace the Internet enthusiastically. Instead, their approach to this new tool has been timid. Why? Because the Internet is not a laparoscope, which, with its shorter stays and recoveries, has quickly proved beneficial for patients. With the Internet, the benefits are less clear-cut. For some, the laparoscope seems like nuts-and-bolts medicine, while the Internet seems like bytes and bolts for nuts.

Yet, much as the laparoscope has changed cholecystectomies and will change other operations in the future, the Internet has already expanded the way many people see the world and will alter the way the medical world interacts. The laparoscope's coinage is gallbladders and tumors; the Internet's is words and information. At the risk of sounding Tofflerian, I predict the near future will see doctors talking to colleagues and patients via the Internet or its offspring. This newest communication tool may even partly supplant the telephone.

My futuristic fantasy has a tarnish. Beneficial, new technologies can kick back; all gadgets can break. In his recent book, "Why Things Bite Back: Technology and the Revenge of Unintended Consequences," Edward Tenner examines unexpected ripples in the history of human invention. Just as the ease of laparoscopic cholecystectomy may lead to excess procedures, so the ease of communicating on the Internet can degenerate into personal assaults fired anonymously into cyberspace. Or the Internet can relegate us to our cocoons, where electronic threads form our only touch.

So what will medicine do with the Internet? If we realize that our job is more talk than technique, we will see that this revolutionary technology can help us educate, collaborate, and communicate. The next "Hamlet" or "Great Gatsby" may not first appear on the Net; the next Osler or Harvey may not disseminate wisdom primarily over the cyberwaves. But the Internet is and will be a major purveyor of medicine's words to patients, others in medicine, and the world.

.....
—Charles Meyer, M.D., Editor-in-Chief

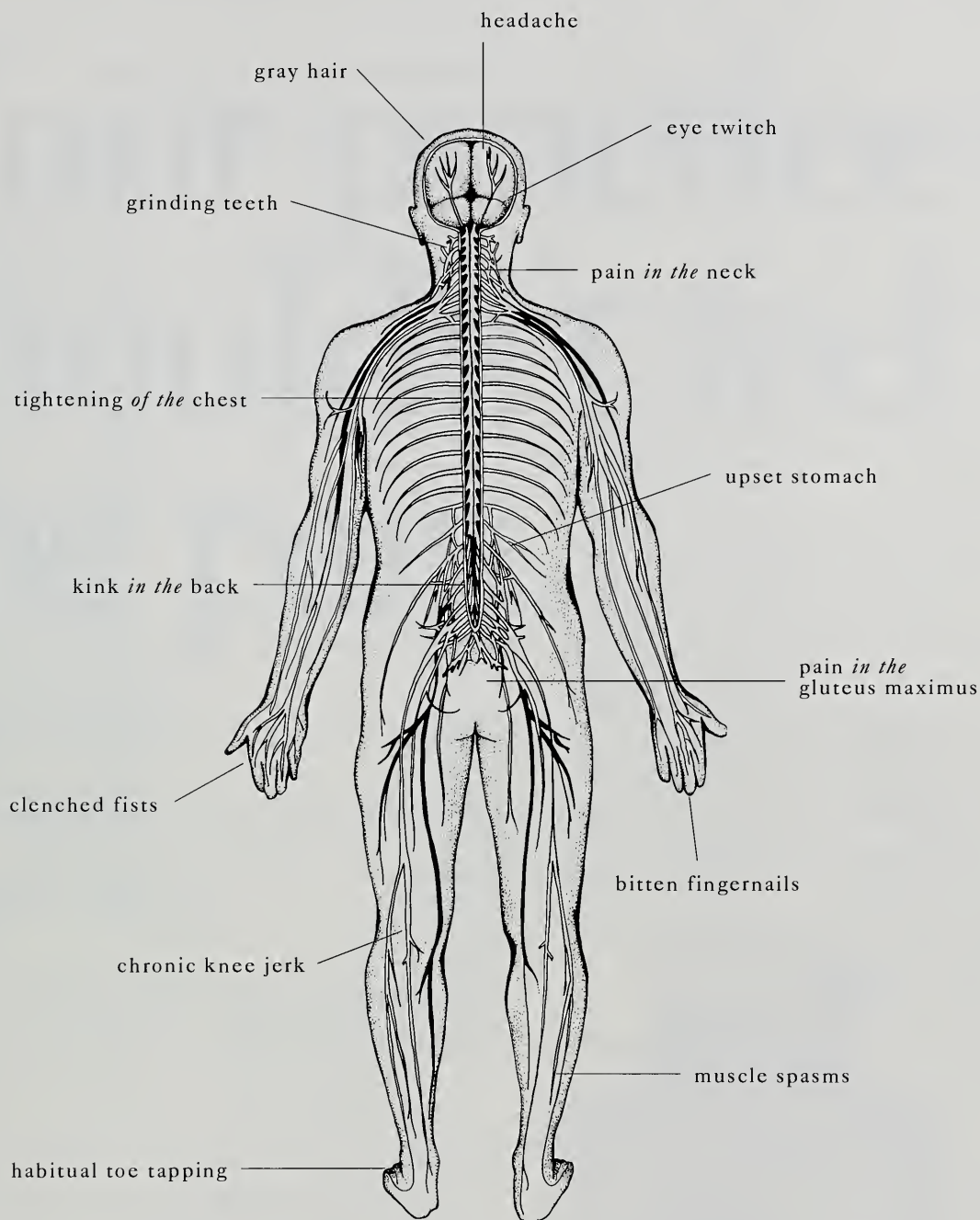


Figure 23

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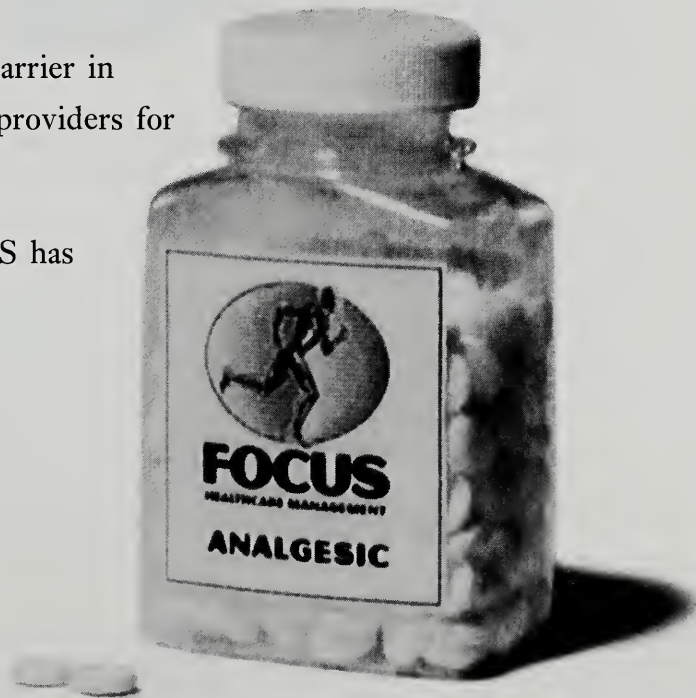
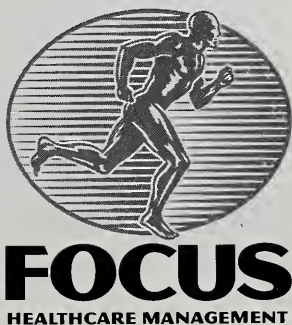
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Physicians Should Not Ration Patient Care

The June issue of *Minnesota Medicine*, devoted to managed care ethics, provided great food for thought.

Twentieth-century medicine in the United States started out as fee-for-service. When health insurance came into existence, insurers simply calculated their cost of business, added a "fair profit," and charged accordingly. When third-party payers began maximizing profits for shareholders, paying for medical care became a whole new ball game.

Many patients realize that their health insurer may be more interested in denying rather than providing them health care. They also know they may have little choice in directing their own health care decisions.

Some contributors to the June issue advanced the argument that, with limited health care resources, a physician's obligations to the patient could be overshadowed by the physician's obligations to the welfare of a group, a community, or society in general. As a past member of the United States Government Biomedical Delegation to the Soviet Union, I have seen firsthand the chilling effect of medical practice based on the ethics of the state. I do not believe

we in Minnesota wish to emulate this form of practice. Perhaps *Minnesota Medicine* should publish a copy of the Hippocratic Oath in each issue so readers can revisit physician ethics on a regular basis.

Physicians can help cut health care costs by focusing on prevention and post-treatment patient health maintenance, not by denying patients appropriate treatment. Meanwhile, we should all work to enhance, rather than dismember, the Hippocratic ethic of patient care.

Charles Burton, M.D.
Senior Medical Director
Institute for Low Back and
Neck Care
Minneapolis, Minnesota

Managed Care Has Yet to Control Costs

In his article, "Gatekeeper Liability and Managed Care" (*Minnesota Medicine*, September 1996), Mr. James Platt is right on the money, with one exception. When he says, "Minnesota has found the right balance between providing good patient care and controlling costs," he is insinuating that managed care controls costs.

I have yet to see one study that proves managed care controls costs in health care delivery. The pennies

saved at the pharmacy and doctor's office are not balanced by the dollars spent in bureaucratic paper shuffling and executive compensation. To commend managed care for reducing health care costs is a bit like lauding the Internal Revenue Service for efficient revenue collection.

We as physicians owe it to our patients, and our profession, to discuss openly the darker side of managed care.

James E. Kettelkamp, M.D.
Oxboro Clinics
Minneapolis, Minnesota

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The Best of Both Worlds

Paul Kleeberg, M.D., has found a way to combine what he loves—patient care and improving physicians' access to information on the Internet.

By Vicki Stavig

On a clear, crisp day, the type Minnesotans savor before facing another long winter, Paul Kleeberg, M.D., sits in his empty office near downtown Minneapolis. He is *not* thinking of the weather. Recently hired by Allina Health System to help develop an Internet health site for its Medica Health Plan, he is waiting for his furniture to arrive.

Earlier this year, Kleeberg helped Allina design its presence on the World Wide Web. That consulting work led to his current responsibilities. "They saw me as a person who could help make information technology useful and usable for physicians in the trenches," explains Kleeberg, also a family practice physician in St. Peter, Minnesota.

Kleeberg was a natural choice. He has technical expertise in computers and practical knowledge of what family practice physicians, particularly in rural areas, need. In 1990 he found a way to bring these two worlds together. On his own initiative, he created Fam-Med, a clearinghouse on the Internet for family practice physicians interested in information technology. Now, at his new job, his experience will have a direct payoff. "I'll definitely use what I've learned from Fam-Med at Allina," says Kleeberg. "On occasion I pose some questions to the discussion list that relate to my work here." While Fam-Med isn't part of his job, he plans to see that it continues.

As Kleeberg's fingers fly across the keyboard of his PowerBook, he clearly enjoys explaining how subscribers use Fam-Med. "They seek and offer advice on various topics, from available drug interaction software to electronic medical record options," he says. For example, one physician might offer an opinion on confidentiality and networked electronic medical records (EMRs), while

another might request information on a program dealing with the medical histories of patients.

Subscribers receive the free Fam-Med service in one of two formats: unmoderated, which means they receive all messages sent; or moderated, a digest of all messages minus irrelevant notes.

"I monitor the discussions closely and try to keep subscribers on the topic," Kleeberg says. "That's when my background in psychology comes in handy. I send out the digest twice a week and have created an archive that is searchable, with a summary of the digests."

While Kleeberg enjoys learning about computers—what he knows, he's taught himself—he admits that busy physicians may find the task formidable. "One of the key reasons physicians don't use this technology is that if it doesn't work or they have a problem, they don't have the time to figure it out," he says. "A CAT scanner is easier to run than a computer," he adds, "because it comes with an operator."

In Search of a Career

Surprisingly, medicine and computers were not part of Kleeberg's original career plans. "I took on medicine late in life," he says. A native of New York City, Kleeberg received an engineering scholarship to the University of Rochester in New York, then switched his

major to psychology and graduated in 1977. However, the job market at the time was shrinking. Consequently, between stints as a youth counselor with Project Challenge, a youth division aide for the State Division for Youth in New York, and a community youth worker for the YMCA of Monroe County, Kleeberg worked as an auto mechanic and construction worker.

Then in the early 1980s, while on a camping trip with a friend, his life took a major turn. "My friend, who had planned to major in psychology but had gone into engineering instead—the exact opposite of what I had done—said medicine was a natural marriage between engineering and psychology," says Kleeberg. "It made perfect sense to me, and we agreed we would both go into medicine. I did; he went into advertising. He sure did a good sales job on me!" he adds with a laugh.

Although friends tried to discourage Kleeberg from entering medical school at age 27, he was determined. He used his inheritance from his mother to pay for medical school. While completing premed studies at the University of Rochester, Kleeberg applied his psychology training in his role of graduate resident adviser for two dormitories, acting as an informal counselor and promoting a healthy living environment.

"Then I got into Stanford, the medical school of my dreams," he says. He entered in 1984. The following spring, he bought his first computer, an Apple Macintosh. "I immediately realized how good it was at storing and retrieving data," Kleeberg says. "I was sold on the fact that my computer would have a key role in my practicing medicine; it was going to be my assistant."

Kleeberg was so impressed with the computer's capabilities that, while working as a teaching assistant in biostatistics,

he convinced the professor to have students do a portion of their work on computers. "It was the first course at Stanford Medical School that ever required computers," he says proudly.

Fam-Med

Kleeberg's computer campaign was just beginning. From 1989 to 1990 he served as a student observer on the American Academy of Family Physicians' Board of Directors, which was setting up a family practice section on the American Medical Association's computer network service. The service—not accessible through the Internet—provided information such as a database of family practice residency programs. Kleeberg encouraged the academy to hook up to the Internet so the information would be more widely accessible.

"They were opposed to that," Kleeberg


KLEEGERG continued on page 61

"One of the key reasons physicians don't use computer technology is that if it doesn't work or they have a problem, they don't have time to figure it out."

—Paul Kleeberg, M.D.



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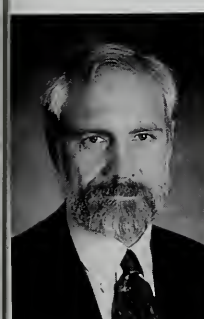
Dr. Crowson will also provide senior leadership for the group and oversee its clinical, operational and financial performance. In addition, Dr. Crowson will continue to serve as president of Ramsey Foundation.



Macaran Baird, M.D., M.S.

Associate Medical Director, Primary Care

Dr. Baird joined HealthPartners in 1995 and has a distinguished career in family medicine, including serving as chair of the Department of Family Medicine at the State University of New York Medical School at Syracuse.



Brian Rank, M.D.

Associate Medical Director, Medical Specialties

Dr. Rank brings a wealth of experience to the group, including more than 10 years at Hennepin County Medical Center. There he held many posts, including director of the Residency Teaching Program, director of the Hematology/Oncology Program and director of the Autologous Bone Marrow Transplant Unit.



J. Daniel Nelson, M.D.

*Associate Medical Director,
Surgical Specialties*

Dr. Nelson has served as chief of Ophthalmology at St. Paul-Ramsey Medical Center and is an expert in diseases of the cornea. He has also served as director of Ramsey Foundation and Ramsey Clinic.



Daniel R. Hanson, Ph.D., M.D.

*Associate Medical Director,
Behavioral Medicine*

Dr. Hanson is an assistant professor in the Department of Psychiatry at the University of Minnesota and an adjunct professor in the University's Department of Psychology. He previously served as chair of Ramsey's Department of Psychiatry.



Richard Heinrich, M.D.

*Assistant Medical Director,
Behavioral Medicine*

Dr. Heinrich will also provide leadership for the group's Behavioral Medicine Division. He has served as chair of the HealthPartners Mental Health Department since 1991.



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Dr. Baines heads the departments of After Hours Care and Continuing Care which include urgent care clinics, home care, geriatric, hospice, social work, and volunteer programs. Dr. Baines is also a deputy medical director for St. Paul-Ramsey Medical Center.



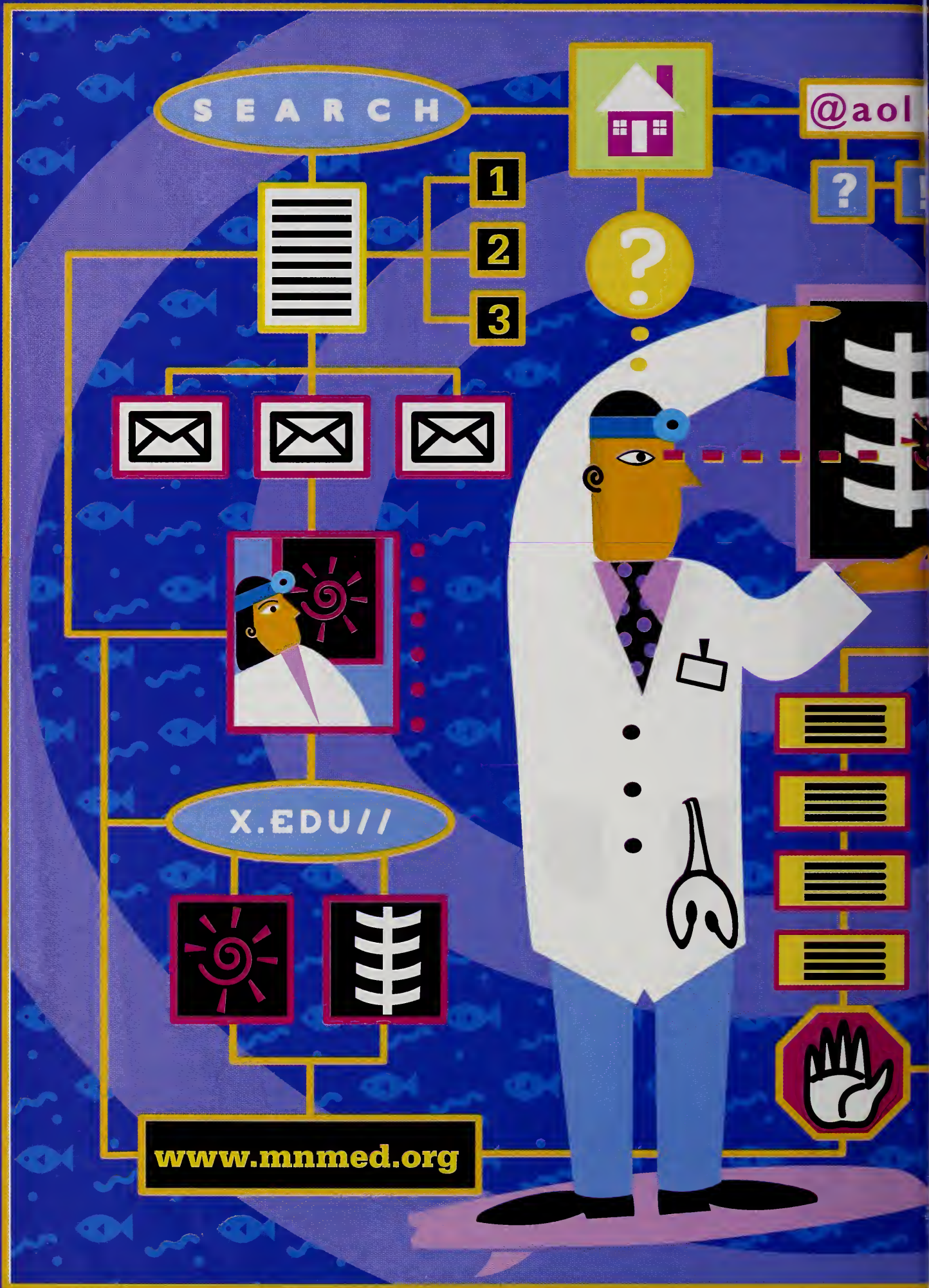
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LET'S GO SURFING!

A Physician Guide to the Internet

Minnesota Medicine's editor-in-chief invites you to learn the newest "sport" in medicine—surfing the Net.

What's the most irritating word for the digitally challenged? The Internet. That cryptic computer conglomeration crops up everywhere. It's in the newspaper daily. Al Gore says you gotta be there. People no longer have respectable addresses with streets, cities, and states, but rather bizarre concoctions of @'s and .'s. For the Internet-ignorant or agnostic, the superhighway convoy evokes supreme ambivalence. You feel lonely as the caravan leaves without you, yet you're not sure you really want to get on.

Here is an attempt by a regular attendee of SA (Surfers Anonymous) to prime our a-technical medical readers with a working understanding of the "Net." While the current flurry may be ephemeral hype, I suspect that future physicians will need to know how to navigate the Internet or its descendants, so here's a primer to plug docs in.

What Is the Internet?

Started in 1969 as ARPANET (Advanced Research Project Agency Network) by the Department of Defense, Rand Corp., and a few universities, the Internet branched like grapevine around the world, linking primarily government and educational computers, which allowed researchers and educators to share data. For years it blossomed in this restricted biosphere with access limited to these institutions. Around 1990, access points to the Net began to multiply, first through dedicated access providers

BY CHARLES R. MEYER, M.D.



and then through popular on-line services like America Online and CompuServe. Soon, a flood of users plugged into a communication medium unlike any previous. The rush was accelerated when access technology became cheaper, when millions of established users connected with each other through on-line services, and when user-friendly, appealing applications like the World Wide Web were developed. The estimated number of host computers mushroomed from 1 million in January 1992 to 7.5 million in January 1996.

So what is the Internet, really? Think of it as millions of essentially unattended computers, called servers or host computers, all over the world, linked by high-speed telephone lines. Servers have two functions. First, they are data banks storing programs, information, and files available to whoever logs on. Second, they are relay stations that pass requests from computer to computer. The requester usually doesn't know what path a given request takes, and, like any web, there are lots of different ways to get from point A to point B. From your humble IBM or Macintosh, the Internet provides virtually instantaneous connection to millions of other computers or people around the world.

If organized, the Internet would be a potentially unlimited universe of communication and knowledge. The rub lies in the phrase "if organized," for the Internet has grown like a community without zoning regulations or telephone books. Everybody has an address, but it's hard to find the Smiths. Restaurants sit next to factories. The first inhabitants of cyberspace tolerated, and probably enjoyed, this friendly chaos. Now the lack of organization has become a major roadblock to using the Internet.

Connecting to the Net

How do you get from your home computer to the Internet world? To start, you need a modem and software. So armed, you contract with one of three entry points—an institutional server, independent service provider (ISP), or commercial service.

The University of Minnesota is one example of an institutional server. Alums from the Twin Cities campus who are members of the University of Min-

nesota Alumni Association and live locally can purchase 50 hours per month of Internet access for \$110 a year. They can either purchase the software to make a connection from the university computer services or use some of the shareware programs available on-line.

ISPs are commercially run services that provide modem connection to the Internet for a monthly fee. Like most computer-related products, ISPs' prices have plummeted from initial offerings a few years ago. I have seen ads for ISPs charging \$19.95 per month for unlimited access with connection software thrown in.

Perhaps the largest influx of new Internet users has come from commercial services such as CompuServe, America Online, and Prodigy. All offer Internet link-up through their standard connection, with software included or as an add-on. Rates vary almost week to week but tend to be more per hour than flat capitation (to use a term

familiar to our medical audience).

When I first ventured onto the Net a few years ago, the software setup process was daunting and demonic, fit only for the technologically addicted. Installation has since improved, and connection should be possible for even the most computer-cautious.

What's on the Net

During its early development, the Internet spawned a zoo of colorful names and acronyms for services that allowed users to access its content: Archie, Veronica, Usenet, FTP, Gopher, WWW. Baffling commands in the computer language UNIX—favored for years by many academic institutions—added to the confusion. Fortunately, although all these services still exist, commands have been simplified.

Here's a sampling of some of the main uses of the Internet.

E-mail

On the Internet, you either send or retrieve information. The main vehicle for communication is electronic mail, or E-mail, which is such a staple in corporate America that most people understand the principle. Using a mail software program, you can



send messages or files directly to another computer by merely typing in an Internet address (see sidebar below), connecting to your provider, if necessary, and clicking send. Retrieving mail sent to you is equally simple; you just click on an electronic "mailbox" where messages are stored on your computer. Like the U.S. mail (dubbed "snail mail" by E-mail elitists), receiving E-mail is fun. But like paper mail, E-mail can get out of hand (see the following discussion of listservs). And, unfortunately, like regular mail, unsolicited junk mail may find its way into your mailbox.

Discussion groups

The Net also allows you to communicate through discussion groups, most of which are organized in

Usenet (see the glossary, page 18). Arranged by topic, discussion groups embody the diversity of the Internet. Just imagine what you could learn reading what (mostly knowledgeable) people are writing about computers, medicine, or politics!

You can participate two ways: by checking into the group, reading the messages that have been posted, and, perhaps, replying to those that spark your creative juices; or, by subscribing to a listserv, an intriguing variant. Listservs are like giant message distribution centers for discussion groups. Anyone wishing to post a message sends it to the discussion group's distribution center (usually an automated computer program), which bundles up all messages daily and forwards them by E-mail to all who have subscribed to that group. ➡

INTERNET ADDRESSES—Where the action's @

Two types of addresses are used on the Internet: E-mail and uniform resource locator (URL).

E-mail Addresses

E-mail allows a computer user to send a message to someone at another computer or terminal. The message is sent to the recipient's E-mail address.

An E-mail address contains two main parts separated by an "@" sign. To the left of the @ sign is the user ID, usually some form of the recipient's name. To the right is the address of the domain, which describes where the recipient's Internet server is located. For example, my personal E-mail address is **meyer073@gold.tc.umn.edu**

Each part of the domain is separated by a period and has meaning. In my address above, the main domain is "umn," which refers to the University of Minnesota. Both "gold" and "tc" are subdomains referring to the gold mail server and the Twin Cities campus. The last item of the domain signifies the domain type. In my address, "edu" identifies the University of Minnesota as an educational institution. Other examples of domain types are "com" for commercial and "org" for organization.

URL Addresses

Uniform resource locator (URL) is a globally

agreed upon method of addressing information stored on computers around the world. For example, a URL can be used to reach an organization's World Wide Web home page, such as the University of Minnesota's at **http://www.umn.edu**

URLs generally follow the format **access type://domain name/directory/subdirectory/file name**. The above address for the University of Minnesota contains only the access type "http://" and the domain name "www.umn.edu"

The most common access type used on the Web is "http" (see glossary, page 18). Sometimes, this part of the address can be deleted, as with the Minnesota Medical Association's home page address, **www.mnmed.org**

Directory, subdirectory, and file name information, when included, specify where information is stored on the server. A string of directories and file names can make the parade of slashes quite long, as in the address for *Rhode Island Medicine*: **http://biomedCS.biomed.brown.edu/RIMedicine/RIMedicine.html**

Fortunately, all current Web browsers allow users to "bookmark" favorite URLs, forming a personal directory of addresses. Once an address is bookmarked, the user no longer has to type it in, but can instead choose it from the personal directory. —CRM

The advantage of a listserv over a regular discussion group is that you get the messages without having to "go" to the group. The disadvantage is that listservs can become the sorcerer's apprentice, madly dumping kilobytes of messages that you have no time to read into your mailbox. Fortunately, you can stop the apprentice with a simple "unsubscribe" message to the distribution center.

The World Wide Web

I have saved the best for last. More than any other service, the World Wide Web (WWW or the Web) moved the Net from a haven of tinkers and academics to the masses. The Web replaced confusing UNIX cryptography with the friendlier, now familiar-looking Windows or Macintosh screen.

Called the Web because of the interconnecting links described below, the Web offers colorful editions of newspapers, video and audio clips of historical events, and information about products and services from businesses around the world. Virtually any interest or topic has some presence on the Web.

The Web uses something called links to help you navigate or browse through information. Links appear as text (called hypertext) or graphic images you can select with your mouse to bring up related Web sites and files. For example, clicking on the name of a specialty society listed in the Minnesota Medical Association's Web site brings up that society's home page. Links are easily identified because the cursor turns into a hand as it moves over the link. In addition, hypertext links usually appear on screen underlined and in blue.

Hypertext is like a bibliography at your fingertips. However, it has disadvantages. Users may feel scatterbrained, flitting aimlessly from hypertext to hypertext without ever following a coherent thought process. Indeed, some critics warn it may become the main etiology for attention deficit disorder in the future. Users may also find themselves at a dead end before ever finding the information they seek.

Touring One Doctor's Workstation

Now that you have an understanding of the terminology, it's time for a tour of the Charles Meyer workstation to see how I use the Internet.

The focus of my daily work away from patients is the telephone and the computer. Since the computer is right there where I work, I can send and receive messages and retrieve information right from my desk. I am doubly digital at my office. With my "digits" I type office notes using a word processing program. I send and receive faxes. I access a CD-ROM

PDR with two clicks. And I connect to the Internet. Here's what I've found in my office laboratory.

E-mail

E-mail works best if it comes to you without any effort, popping up on your screen. Not all connections to the Internet allow this, so periodically checking your mailbox is necessary. To whom do I write? Besides family and friends, I communicate with colleagues about patient issues, with my co-workers at *Minnesota Medicine*, and with people I have contacted via lists or discussion groups.

Quick look-up

Medline searching can be quick and cheap over the Internet through the National Library of Medicine located at <http://igm.nlm.nih.gov/> (see the sidebar, page 19, for the addresses of several medical Internet sites). I found 15 citations on laparoscopic hiatal hernia repair in three minutes. A site at www.travelhealth.com has country-indexed immunization travel information.

Searches of the entire Internet using search engines like Infoseek and Alta Vista (explained on page 19) can yield new information not available in the office. I recently got two descriptions of the new diet pill, Redux, that weren't available in the PDR or other office references. Warning: Such searches of the entire Web can produce detritus, and refining your searching technique can take time.

Journals and discussion groups

Journals on-line include *The New England Journal of Medicine* (<http://www.nejm.org/>), the *British Medical Journal* (<http://www.bmj.com/bmj/>), *Lancet* (<http://www.thelancet.com>), *Annals of Internal Medicine* (<http://www.acponline.org/journals/annals/annaltoc.htm>), and the journals published by the American Medical Association. Each has its own approach to how much full text material it includes, but all have tables of contents for recent issues. (See "Medical Publishing Goes On-line," page 26.)

Medically oriented Usenet groups such as sci.med.radiol and misc.emerg-services and sci.med.telemedicine host discussions for lay persons and professionals. To access these groups, you must use the news reader portion of your software.

Patient information

Patients can get reliable medical information on most topics at hundreds of sites. They can read a description of asthma and its treatment. They can view drawings of a hernia. They can even locate support groups for chronic diseases. The National

Heart, Lung and Blood Institute's Web site located at gopher://fido.nhlbi.nih.gov/ and the National Institute of Diabetes and Digestive and Kidney Diseases' site at <http://www.niddk.nih.gov> provide patient education papers on topics from prostates to brains.

Connection to professional organizations

The AMA has a large Web site at <http://www.ama-assn.org>. The Minnesota Medical Association's new site at www.mnmed.org contains links to national specialty organizations like the American Academy of Ophthalmology (see "MMA Unveils World Wide Web Home Page," page 20).

CME

I sense an impending explosion of CME for credit on the Web. A site at <http://medicus.marshall.edu> provides a case presentation in which you choose the questions to ask in the history (in your own words), to which it gives answers. When you're ready to move to the physical exam, the screen shows a photograph of a patient on an exam table. When you point to the location you want to examine, you are given the findings. You select lab and x-ray from one drop-down list and choose your diagnosis from another. After you submit your diagnosis for evaluation, you fill out the CME evaluation form, pay \$15, and receive credit. A two-page evaluation of the case is immediately E-mailed to you.

The Internet's Potentials and Dangers

Although the Internet is entertaining, I do not agree with William Gibson, who recently wrote in the *New York Times* that the Internet "in its clumsy, larval, curiously innocent way, offers us the opportunity to waste time, to wander aimlessly, to daydream about the countless other lives, the other people, on the far sides of however many monitors in that postgeographical meta-country we increasingly call home."

As an incurable goal-directed denizen, I dream of a galactic library with experts on all floors eager to answer questions. The Internet isn't there yet.

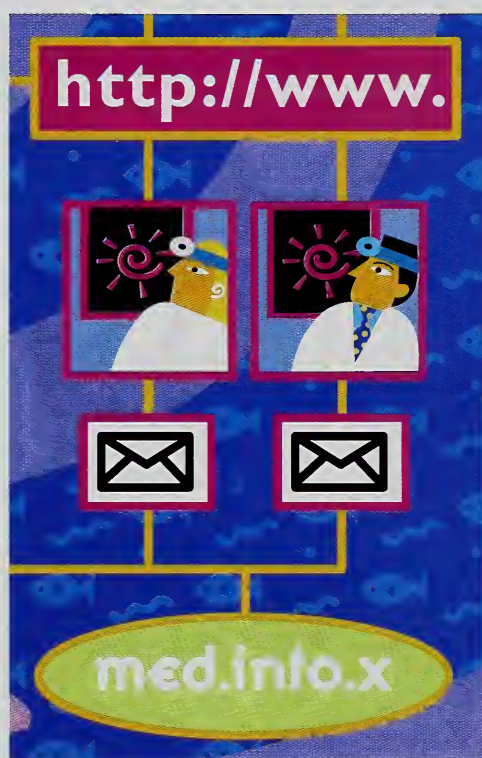
Now it's like a library with no classification system where half the books have only a cover and an introduction. The Internet needs an index to harness the untamed information and provide quicker look-ups. It needs to provide the full content of an article, book, or report so true research can be done. Medical experts are out there, but like other quality content, it takes time and a high frustration threshold to get to them.

Are there dangers to the information superhighway? Clifford Stoll, an adept cyber-chie who made his name nabbing a foreign Internet hacker and writing about the chase in "The Cuckoo's Egg," sounds a cautionary note in his most recent book, "Silicon Snake Oil." He fears a world devoid of human contact that has abandoned the warmth and wisdom of books and lost a moral core. Similar strains are heard in the book "Gutenberg Elegies" by Sven Birkerts. Indeed, surfing threatens to supplant socia-

bility. As any Nintendo-battered parent can attest, electronics can be addictive. The *Canadian Medical Journal* reported on "Internet addiction syndrome" with all the features of true addiction, including "loss of control, cravings and withdrawal symptoms, social isolation, marital discord, academic failure, excessive financial debt, and job termination." Others warn of future gridlock as the nation's data network collapses under the weight of thousands of new surfers each week.

But I suspect the Net and the Web are here for the long term. The indexes will be refined, the data lines will multiply, and we will all continue to talk to real people. It will demand perspective, so the alarm that Stoll sounds should not be ignored. The Internet is overwhelming. It is educational. And it is fun. Medicine and doctors need to be there. Grab a board—surf's up. ➡

Charles Meyer, a frequent Internet surfer, is editor-in-chief of Minnesota Medicine and an internist with Consultants-Internal Medicine in Minneapolis.



GLOSSARY OF INTERNET TERMS

BOOKMARK—A list of a user's favorite home pages kept by Web browser software and used for quick return to favorite sites.

BROWSER—A software program, like Netscape or Internet Explorer, used to communicate with servers, retrieve and read Web documents, and follow hyperlinks to other documents.

DIALUP CONNECTION—Access to the Internet that requires the user to dial into an Internet service provider using a modem and telephone line.

ELECTRONIC MAIL (E-mail)—An electronic system whereby a computer user can exchange text messages with other computer users via a communications network. Can be used to broadcast a message to a group of users.

FAQ—Short for frequently asked questions, a common acronym on the Internet. For example, a medical site might have a heading "FAQs on Cancer."

FLAME—A scathingly angry or contentious response to a newsgroup posting or a piece of E-mail.

FTP—File-Transfer Protocol. The Internet protocol that governs the transmission of files between two computers. Sometimes an account is required, but often a server will allow "anonymous FTP," which means that its files are publicly accessible.

GOPHER—Developed at the University of Minnesota (and named after its mascot, the Golden Gopher), a hierarchical, menu-based software for navigating the Internet.

HOME PAGE—The first page of a Web site.

HTML—HyperText Markup Language. HTML is the language in which Web pages are written. It's used to create formatting and links to other documents on the Internet.

HTTP—HyperText Transport Protocol. The protocol for connecting and transporting hypermedia Web documents across the Internet. HTTP supports the embedding of hyperlinks in the documents.

HYPERLINK (or link)—A word or image in a Web document that when selected by clicking on it with your computer's mouse connects you with a new site, page, or even a different location on the same page.

HYPERMEDIA—The integrated text, graphics, audio, video, animation, etc., in Web documents.

HYPERTEXT—Text that links to other files, even files on other computer networks.

INTERNET PROVIDER—A company that provides a gate-

way or access to the Internet. It offers customers an electronic connection (direct or through a modem) to the Internet, as well as software and services.

LISTSERV—An electronic discussion group. Subscribers receive every message via E-mail.

MODEM—A device that attaches to your computer and converts the signals generated by the computer to signals necessary for transmission over telephone lines. An abbreviation of "modulation-demodulation."

NETSCAPE NAVIGATOR—Currently the most popular Web browser.

NEWSGROUPS—Also known as Usenet discussion groups, which are electronic forums on every conceivable subject. Postings (or messages) are sent to a central delivery system. Readers can respond by using various newsreader software. Arranged hierarchically, newsgroups start with prefixes, such as sci. (science), rec. (recreation) and alt. (alternative).

PAGE (or Web page)—A single Web document. A Web page may not fit on a monitor screen or on a standard sheet of paper. It can be very long, requiring users to scroll through it. One Web page may take several pages when printed on paper.

PROTOCOLS—The specific communication standards that computers must follow to interact with other computers.

SEARCH ENGINE—Search engines are software programs employing a variety of strategies to locate Web sites.

SERVER—A computer that shares its services, such as printers and files, and information with other computers on a network and is often dedicated to centralized file storage.

SHAREWARE—Software that is freely distributed on networks. After a specific trial period, users must register and pay a nominal fee. Freeware is distributed in the same way but requires no fee.

SITE—A group of related interlinked pages located on a specific server and with its own address or URL.

URL—uniform resource locator. A standard address format needed for World Wide Web browsers and now becoming the common way to identify the location of any Internet resource. Example: <http://www.med.yale.edu/library/>

USENET—See newsgroups.

WORLD WIDE WEB (WWW or the Web)—A hypertext-based information retrieval system that links documents and data on the Internet and allows users to hear sounds and view text, images, and movies.

MEDICAL INTERNET SITES

REFERENCE LOCATIONS WITH LINKS TO OTHER SITES

Galaxy-Medical

Medical section of a general information catalog.
<http://galaxy.einet.net/galaxy/Medicine.html>

Jonathan Tward's Multimedia Reference Library

Medical information organized by specialty. Infectious disease section organized by disease.
<http://www.med-library.com/>

Martindale's Health Science Guide

Extensive medical reference with multiple links.
<http://www-sci.lib.uci.edu/HSG/Medical.html>

Medical Matrix

Medical index by category.
<http://www.slackinc.com/matrix/>

Medline

Access to the National Library of Medicine.
<http://igm.nlm.nih.gov/>

MedNet

Extensive series of links by subject.
<http://www.mednet-i.com/links.html>

PSL Group

Medical news, mostly in the form of news releases. Quite comprehensive—includes new drugs.
<http://www.pslgroup.com/mednews.htm>

SPECIALTY-SPECIFIC SITES

Family Practice

Section of University of Iowa's Virtual Hospital with extensive summaries of clinical information in outline format for family practice.
<http://indy.radiology.uiowa.edu/Providers/ClinRef/FPHandbook/FPHHomepage.html>

Internal Medicine

American College of Physicians' home page.
<http://www.acponline.org/index.html>

Neurology

Job opportunities, links to neurology information.
<http://www.neurosource.com/>

Ophthalmology

American Academy of Ophthalmology home page.
<http://www.eyenet.org>

Pathology

Univ. of Alberta Department of Pathology. Links to pathology images like adrenal pheo and brainstem hemorrhage.
<http://fester.his.path.cam.ac.uk/big/synapse/000p0116.htm>

Radiology

Click on anatomic icons for choice of cases to view with history, physical findings, and selected images.
<http://johns.largnet.uwo.ca:80/med/i-way.html>

Univ. of Washington Radiology, virtual case of the week.
<http://www.rad.washington.edu/>

Rheumatology

American College of Rheumatology home page.
<http://www.rheumatology.org/>

PATIENT INFORMATION

Duke University Medical Center

General medical information with pediatric emphasis.
<http://www.mc.duke.edu/>

National Heart, Lung and Blood Institute

One- to two-page descriptions of common health concerns like blood pressure, coronary disease, and smoking.
[gopher://fido.nhlbi.nih.gov/](http://fido.nhlbi.nih.gov/)

National Institute of Diabetes and Digestive and Kidney Diseases

Descriptions for diabetes and digestive, hematologic, and genitourinary diseases.
<http://www.niddk.nih.gov>

Oncolink

Cancer database for patients and professionals.
<http://cancer.med.upenn.edu/>

University of Iowa's Virtual Hospital

General information organized by organ system and department; virtual textbooks.
<http://vh.radiology.uiowa.edu/Patients/Patients.html>

University of Washington Health Links

Compilation of links to other patient information on the Internet organized by topic.
http://www.hslib.washington.edu/your_health/index.html

GENERAL SEARCH TOOLS

These sites allow you to enter search term(s) to search the entire Internet for keywords. The various search "engines" can produce vastly different search results from the same keywords, so it pays to try a few.

Alta Vista

<http://www.altavista.digital.com>

Infoseek

<http://www.infoseek.com>

Yahoo

www.yahoo.com

mma.unveils.world.wide

The Minnesota Medical Association
has provided its
physician members
a port of entry into
cyberspace to help
them get to better
know the association
and navigate the Web.

By Steve Dombrosk

doubt move beyond our home page, but we encourage them to begin their on-line time at the MMA site.

Mission

We also intend to use our Web site to enhance the MMA's fundamental mission, namely, to serve as an umbrella organization for physicians who practice in all geographic areas of the state and in all the various specialties. The MMA Web site is devoted to unifying the physician community. In fact, the name of our site is not "MMA" but "mnmed.org." We want *all* elements of organized medicine in Minnesota to participate.

To this end, we are offering to host, or include, information from each component society of the association. Several societies have already expressed an interest. Minnesota specialty societies will also be able to participate in the site. Component and specialty societies that prefer to develop a free-standing Web site will be linked to the MMA home page.

The Minnesota Medical Association ventured into cyberspace September 18 with the unveiling of its World Wide Web home page at the association's 1996 Annual Meeting. In doing so, the MMA joined 54 million other pages on the Web, establishing a presence among the several hundred million people who use the Internet.

We don't expect the world to take notice immediately. Our goal is much more modest. We want our home page to be the *first* place Minnesota physicians go when exploring the Web.

In developing a home page site, we had three primary considerations: Who do we want to serve? What organizational aims do we hope to foster? And what should the home page include?

Audience

As a professional organization composed of physicians and medical students, our goal is to meet our members' needs. Physicians require timely, relevant, and clear information. Few professionals suffer from more information overload than physicians, and the Internet threatens to exacerbate this problem. Not only does the Web overwhelm users with its sheer volume of information available, but an almost total lack of organization of that information has become its defining feature.

In light of this, the MMA home page provides physicians a "port of entry" into cyberspace. That is why we suggest our site be a starting point. Physicians will no

home.page

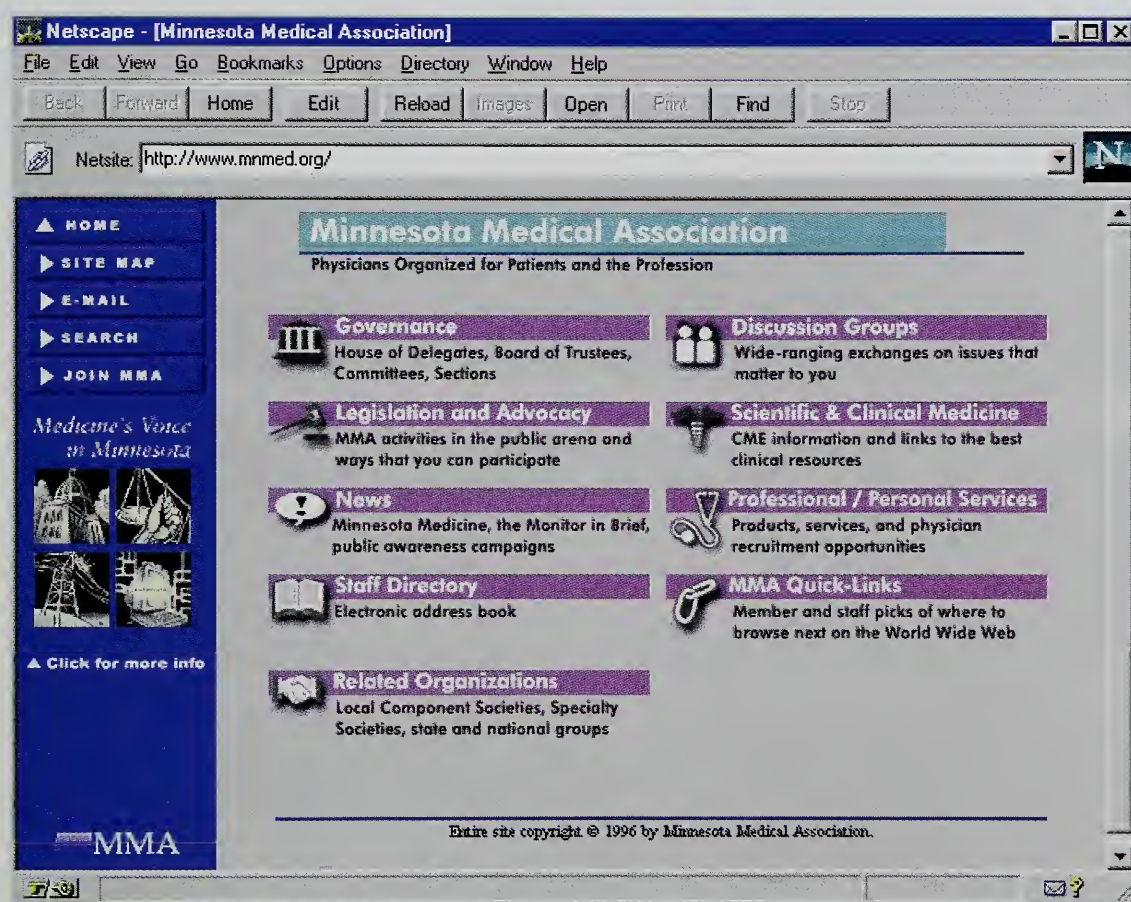


Figure 1:
The MMA
opening
screen, or
main menu

Our Web site will also help us achieve important organizational goals. Physicians who are interested in being involved in MMA activities but have limited time to attend meetings can use the Web site to keep informed of association events.

While it's important to know what's happening, simply being informed isn't enough. The MMA home page provides physicians additional options to participate—a crucial factor in maintaining an active, involved membership. Fortunately, the Internet, unlike publishing and television, is a two-way medium. The MMA Web site contains more than 100 points where members are able to communicate with us.

What Our Home Page Includes

The key to the popular World Wide Web is that you navigate by pointing and clicking—no special knowledge of secret commands is required. The best way to

explore any Web site, the MMA's included, is to visit the site with your computer. When you open the MMA's site at www.mnmed.org you will see the opening screen shown in Figure 1 above.

As you travel through the site, the blue left-hand column remains a point of reference. If you get lost, you can always click on the home button to return to the opening screen. You can use the E-mail button to send messages to MMA staff and officers and the search button to look for information anywhere in our Web site. The search button also contains links to several Internet search programs.

Each of the nine bars on the right panel leads you to additional choices, which are diagrammed in Figure 2 (page 23). You can also view a current version of the diagram by clicking the site-map button on the home page. Following is a description of the information available under each bar on the right panel. ➡

Should Your Practice Have a Home Page?

If you're considering developing a Web page for your practice, it's important to ask some fundamental questions. Who do you hope to reach? Current or prospective patients? Colleagues? The general public? What would you like to accomplish by reaching these people? Once you decide who you want to reach and why, then you must determine what your target audience needs to know and how you can best use the special characteristics of the World Wide Web to meet those needs.

The simplest kind of home page, like a yellow-pages ad, doesn't change. It provides basic information about a business, possibly along with some eye-catching graphics. Many businesses advertise this way to gain visibility and credibility. For this reason alone, practices may want to consider a basic home page.

To update information about your practice regularly requires a home page that's like a newspaper. To create a Web site that changes daily or weekly involves an ongoing commitment to keep your information current.

You can also create a Web site that functions like a talk-radio station. Visitors don't simply look

at your home page; they can also talk back and perhaps see their comments on the screen. Each message you receive must be reviewed, especially if the sender is expecting a response. If you intend to publish comments on your site, review them before publication so that your own Web site doesn't become a source of embarrassment.

How can your clinic get started in setting up a Web page? Word of mouth is always a good source of information, so if a practice in your area has a Web page that you like, ask who set it up. Internet Service Providers, the companies that provide connection to the Internet, are another good source for referrals. A Web site located at www.thelist.com maintains a list of almost 4,000 of these companies.

Which type of Web site is right for your practice? There's no single answer. You may not need a home page at all. Many small and medium-sized practices may find the yellow-pages model a good way to stake a claim in the new world of cyberspace at a reasonable cost. If your practice is large enough to warrant a larger and more elaborate site, chances are you've already started developing one.

	Simple Web Site (yellow-pages style)	Intermediate Site (newspaper style)	Complex Site (talk-radio style)
Key benefit	Provides visibility and basic information	Communicates new information	Combines information with interaction
Frequency of information updates	Monthly or less frequently	Weekly or daily	Daily or more frequently
Initial setup expense	\$50 to \$1,000	\$1,000+	\$5,000+
Monthly Internet connection expense	\$25 to \$100	\$100+	\$400+
Monthly staff consulting expense	Minimal	\$1,000+	\$1,000+

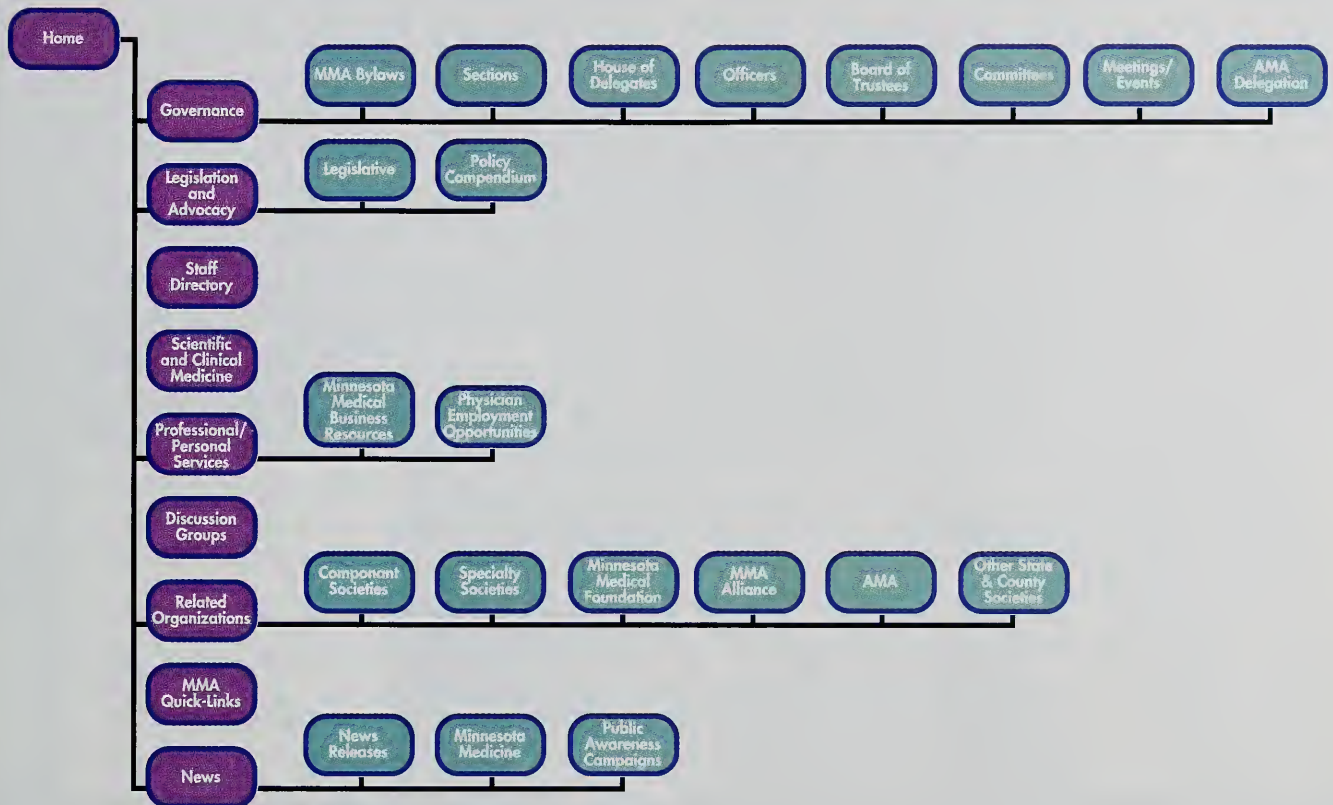


Figure 2: The MMA World Wide Web site map

Governance

The first of the nine selection bars, Governance, has information on the MMA's decision-making bodies. The MMA House of Delegates, Board of Trustees, and various committees all make information available here. Many E-mail links are provided so you can communicate your opinions to the MMA's leadership with a single click. The section also includes an on-line edition of the MMA Bylaws, available for instant reference.

Legislation and Advocacy

The next selection is Legislation and Advocacy. Legislative Alerts and special updates will be posted here regularly, with frequent additions from the MMA's lobbying team during the legislative session. We've also tracked down links to many useful sources of government and political information, along with E-mail links to Minnesota and federal legislators. A special feature of this section is an on-line edition of the official "MMA Policy Compendium."

News

You'll find news from *Minnesota Medicine* and *The Monitor* under the third selection bar, called News. In addition to these MMA publications, you can also view many press releases, as well as information and documents from our public awareness campaigns. The full text of the MMA's resource guide on violence can be viewed, downloaded, or printed from this section of the site, along with other materials on subjects such as gun safety and conflict resolution.

Staff Directory

The next selection provides an electronic directory of MMA staff, with E-mail links that allow you to contact any staff member directly. The MMA staff wants to be accessible to members, and this directory provides another avenue of communication.

Related Organizations

The fifth selection bar, Related Organizations, contains information on MMA component societies and

links to the American Medical Association, national specialty societies, and other state medical groups. State specialty organizations can place information on this portion of the site as well.

Discussion Groups

Discussion is an important part of the Internet, and the MMA site includes several discussion groups under the sixth menu option. Here you can raise issues, ask questions, and share opinions with your colleagues. Based on your interests, you can form subgroups.

Scientific and Clinical Medicine

The seventh menu selection, Scientific and Clinical Medicine, includes links to CME resources and reference sites for obtaining clinical information available on the Web. A key feature of this section is links to several sites that provide free access to Medline, the information service of the National Library of Medicine. As you locate other valuable resources, let us know, and we will share them.

Professional and Personal Services

This section offers information on products and services you can purchase through Minnesota Medical Business Resources, such as insurance, financial planning, and auto leasing. The auto leasing section includes a valuable set of links to major automotive manufacturers, allowing you to visit electronic showrooms with no pushy sales representatives. Also available is a list of physician employment opportunities.

Quick-Links

The last selection, MMA Quick-Links, brings together all the links to other Web sites that are scattered throughout the MMA's site. In addition, "Internet Insights" provides an ongoing guide to resources and information about the Internet itself, while "Diversions" is a collection of links to Web sites that may provide a break from your daily routine.

We invite you to visit our MMA home page at www.mnmed.org and share your thoughts with us! **MM**
Steve Dombrosk, MMA director of Management Information Services, coordinated the Internet project.

Urgent Care

HealthPartners is an organization committed to preventive medicine, health promotion and high quality health care. We are seeking BC/BE Family Practice and Internal Medicine physicians to work evenings and weekends at our Urgent Care clinics.

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Mankato Clinic
Mankato, MN



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A New Frontier:

Medical Publishing Goes On-line

With new and established medical journals venturing onto the Internet, only time will tell if quality medical literature will suffer or flourish.

On-line medical publishing is like the Wild West when it first opened to settlement. Everybody's rushing to stake a claim. Law and order do not prevail. Medical cyberspace pioneers are colonizing the information highway and pressuring medical journals and everyone who talks about medicine to join the wagon train or eat dust.

The Internet is medicine's new frontier. But what exactly is on-line medical publishing? Strictly speaking, it refers to medical journals available on the Internet. Although many forms of medical-related information have moved on-line—such as physician discussion groups, medical databases, CME courses, and patient information—most do not reflect original research in the field.

New and established medical journals are venturing onto the Internet, but until the dust settles, no one knows just how on-line publishing will fare or how it will affect the world of medical literature. To what extent will on-line journals replace paper publishing? What are the advantages and disadvantages compared with paper? And what are the controversies?

"On-line journals have their advantages," says Robert Kennett, vice president of publishing at the AMA, "if they are properly peer reviewed. But they will never replace paper journals."

Although some physicians and publishers are apprehensive, many are embracing on-line publishing. Physicians suddenly have access to a free periodical library and are connected with peers around the world. "It's one more way for people to get information," says Patti Ephraim, managing editor of the *Digital Journal of Urology*, an on-line peer-reviewed journal. "The days are gone when a medical librarian could pull up everything. On-line journals are not confined to the printed page, and you can reply instantly to what you read. Someone in India can see a case presentation in Boston. It's as though we've been given a new kind of printing press."

On-line Journals

On-line journals of all types have exploded in number—by 1,400 percent since 1991, according to the Association of Research Libraries, which publishes the "Directory of On-line Journals, Newsletters and Discussion Lists." Ninety percent of them are available on the World Wide Web.

Two types of on-line journals exist: paper journals that are also available on-line, and journals that are only available on-line. Approximately 300 medical journals and newsletters appear on-line, according to MedWeb, the Emory University Health Science Center's Web site. Med-

Web lists journals by specialty and indicates whether they contain full text, abstracts, excerpts, or a table of contents. According to the National Library of Medicine in Washington, D.C., there are 95 strictly on-line medical journals and newsletters.

Most medical journals that have gone on-line are abridged versions of a paper journal and include excerpts, abstracts, or tables of contents. *The New England Journal of Medicine* offers full text for its book reviews and letters to the editor and abstracts of every original article dating back to 1815. Clicking on the abstract orders the full text. The *British Medical Journal* offers full text to some articles. So does the *Journal of the American Medical Association*, along with letters to the editor, abstracts of all original articles, and a searchable archive.

The eight-month-old *Digital Journal of Urology* is an example of a journal found strictly on-line. Published in Boston by 12 volunteer staff, the journal includes something for everyone: original peer-reviewed articles, patient information, book reviews, CME listings, employment opportunities, and a page called Grand Rounds—urology case presentations from around the world that physicians can interac-

By Howard Bell

tively puzzle out. "We request submittals through the Internet and in mailings through the Urology Association," says Editor-in-Chief Anthony Atala, M.D. The *On-line Journal of Ophthalmology* is similar and includes reviews of CD-ROM references.

Competitive Edge

For on-line journals to compete with paper journals, they must offer something paper can't. "We offer the advantage of speed," says Henry Sacks, M.D., co-editor of the *On-line Journal of Clinical Trials*. "We don't publish issues, we publish continuously. When an article is ready, we put it on-line."

However, physicians typically do not deal with late-breaking, time-sensitive matters daily. Search engines and links to other information on the Internet are the primary on-line advantages for most physicians. These tools connect physicians to related information quickly and make searching and retrieval vastly easier, according to Lisa Freeman, director of the University of Minnesota Press. "You can't beat the speed and ease of searching," she says. "There's just a huge advantage over paper."

Digital information is easier to store, too. It's now possible to store all the current mathematical journals for a much lower cost than subscribing to a single mathematical journal, according to the Association of Research Libraries.

User Apprehension

In the medical field, opinions vary widely on the Internet's usefulness. Michael Green, M.D., a family physician with HealthPartners Como Clinic in St. Paul who became Net-savvy out of curiosity, is among the skeptics. "The Internet has little value for my practice," says Green, "but neither do paper journals." If he's researching a topic for a presentation, Green uses the library. For patient care, he rarely uses journals to find information. "I live in an urban area and can readily consult with subspecialists. Most journals are not that useful to primary care docs."

Green says his clinic's use of on-line medical journals would be too low to justify even a reduced-cost subscription shared with other clinics. He might subscribe to an on-line medical journal just to save paper, but he'd be more likely to subscribe if he worked in rural Minnesota and had less access to libraries and librarians. He says he might subscribe if he needed teaching resources, such as if he was a preceptor with the Univer-

sity of Minnesota's Rural Physician Associate Program, in which medical students are paired with rural primary care physicians. His first choice is CD-ROM references. Green also prefers paper newsletters that abstract articles. "I have a half dozen CDs of references and journals, but I'm just not going to surf journals on the Internet."

Twin Cities-based *Star Tribune* medical reporter Gordon Slovit agrees. "I don't use the Internet," he says matter-of-factly. *Star Tribune* librarians search databases like Medline, then ask the local library that carries the article to send it to Slovit.

"You can't beat paper for portability," Green adds. "You can take it to the bathroom or to bed. And when you fall asleep and it falls on the floor, it won't break." ⇨



ILLUSTRATION BY JAMES O'BRIEN

The AMA's Kennett agrees. "On-line publishing will not change medical publishing. It will just be another medium by which we serve readers." Kennett likens the Internet's effect on paper publishing to TV's impact on radio. "TV was supposed to render radio obsolete, but of course that didn't happen," says Kennett. "We've done tests that repeatedly prove paper's desirability. People aren't going to read journals on their screens. Instead, they'll use the Internet for research and to find specific bits of information."

Goodbye Peer Review?

In a profession that demands quality information, peer review seems particularly at stake. Only about one-third of on-line journals in all disciplines are peer reviewed, according to the Association of Research Libraries. Nobody knows how many strictly on-line journals are peer reviewed. "I'm sure the percentage is low," says Steven Foot, Emory Health Science Center librarian and MedWeb creator.

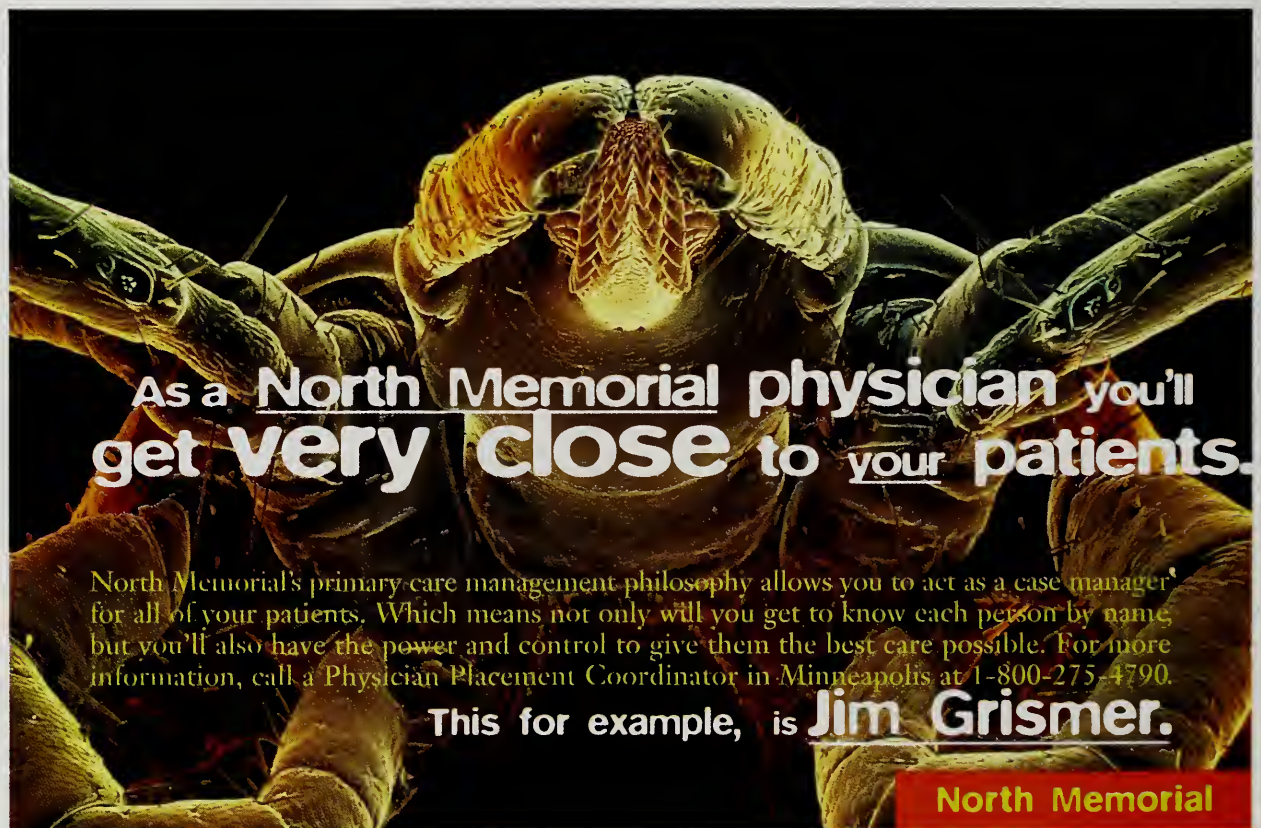
The New England Journal of Medicine is concerned that on-line medical journals are not peer reviewed. In the journal's June 1995 editorial, Editor Jerome Kassirer, M.D., and Marcia Angell, M.D., assert that on-line journals "threaten to undermine time-tested traditions that help ensure the quality of

medical literature." The journal is particularly critical of the proposed "open system" of on-line publishing, a freewheeling, unrefereed exchange of information in which unreviewed medical article abstracts and titles could be distributed daily on the Internet. Anyone who wished to review or comment on the article could do so. Articles would be considered works in progress, amended or updated based on unedited comments and reviews received.

Harvard University, AT&T, and NASA are collaborating on such an open system for reviewing medical research called the "Global Health Information Server." It's expected to be up and running by the end of the year, using epidemiology as a test specialty. It's modeled on a scholarly information exchange server for physicists that Los Alamos National Laboratory has operated since 1991.

Carefully selected peer reviewers cannot be replaced by random, unspecified Internet users, say Kassirer and Angell in their *New England Journal of Medicine* editorial. Open-system peer review should be used cautiously when treating and diagnosing patients, they warn. Naive enthusiasts may liken peer review to censorship, but in medicine such "censorship" is welcome.

"You need to go with sources you trust," says



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This for example, is **Jim Grismer.**

North Memorial

Kennett. "We're dealing with the lives and health of humans."

"The Internet has forced us to reevaluate the importance of peer review," adds Charles Meyer, M.D., an Internet-savvy internist in Minneapolis and editor-in-chief of *Minnesota Medicine*. "I have mixed feelings, because the Internet allows anyone to broadcast their views to a large audience without any intermediary."

Bad information can get into the hands of physicians, patients, or the media and be misused or misinterpreted. Unverified studies or flawed conclusions can harm patient care. "Even with peer review," says Meyer, "there's a lot of junk out there. Radical sketchy research can find its way into the mainstream. Somebody publishes an unverified article saying the stuff they put in cereal is toxic, and next thing you know, it's on the front page."

On-line advocates argue the same happens with printed health information. Someone can as easily misuse medical information taken from a paper journal in the library. Nevertheless, the Internet gives more people easier access to a larger volume of information and, thereby, increases the likelihood for misuse.

Internet supporters say on-line publishing does not threaten the principles of peer review or the

integrity of original papers. The best journals will continue to be peer reviewed whether they are on-line or on paper. Nor do on-line journals pose a threat to established paper journals, according to Meyer. "Whether on-line journals achieve the same level of credibility is the question."

On-line medical publishing will sort itself out over time, supporters argue, eventually forming an on-line hierarchy similar to the paper journal hierarchy. At the top will be peer-reviewed on-line journals, with an established reputation for credibility. Quality research will still gravitate to quality journals with large readership. Information of unknown authorship and reliability will be at the bottom. Readers can decide for themselves what to use. "The Internet does force users to be more discriminating," acknowledges Paul Kleeberg, M.D., a family physician in St. Peter, Minnesota, and creator of an Internet discussion group called "Fam-Med" (see Face to Face profile, page 8).

Many strictly on-line medical journals are not peer reviewed, but that may be more a symptom of their newness than any inherent difficulty reviewing them. On-line journals can and do use peer review comparable to paper journals. Speeding review time while preserving quality can be an on-line advantage. *Digital Journal of Urology* articles are peer reviewed

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within 72 hours of submittal, according to Editor-in-Chief Atala. Even when information is not time-sensitive, ideas get communicated more quickly.

Nonetheless, Kennett feels many on-line journals will not stand the test of time. "I have doubts some are going to make it," he says, "because they lack readership and good information. No one knows the credentials of some of these journals. Many are probably suspect."

The Bottom Line: Cost

It's naive to think on-line publishing will render traditional publishers obsolete. For one thing, no one knows whether on-line medical publishing will, in the long run, be cheaper than paper publishing. Opinions vary so widely that they are almost meaningless. Some say on-line publishing would cost 20 percent to 30 percent less. Others project savings will range from 70 percent to 80 percent. The University of Minnesota's Freeman believes on-line publishing will cost about the same, maybe more. She feels savings estimates are wildly optimistic. "Putting ink on paper is a small part of the cost," she says. "Managers, advisers, and editors are the most expensive parts of the process. When you include those, on-line publishing is not cheap. The world's scholarly information system cannot be run on a wholly voluntary basis. It takes people who are skilled and salaried."

Freeman points out that, currently, most strictly on-line medical journals are free and survive tenuously on the energy and dedication of volunteers. "They are started in people's spare time and don't have institutional support," she says.

A case in point is the *Digital Journal of Urology*, published by volunteers. Anyone can subscribe by submitting an E-mail address. Editor Anthony Atala, M.D., says the journal is seeking sponsorship in return for which the journal will include a hypertext link to the sponsor's Web site.

Paid advertising, used as a main source of revenue for many paper journals, is just emerging in on-line medical journals, according to Emory's MedWeb creator Steven Foot. "It's highly experimental and often based on hits," he says. Hit-based advertising rates are at best unreliable reflections of advertising effectiveness. Most likely to accept advertising are on-

line medical journals produced by large publishing houses. For example, Priory Lodge Education, a British publisher with several strictly on-line medical journals, accepts advertising and sponsorships from pharmaceutical companies and software manufacturers. They also advertise products that other divisions of Priory produce.

In 1996, only 10 percent of paper journals on-line charged subscription or access fees, according to the Association of Research Libraries. For example, physicians can get on-line access to the American College of Physicians' Journal Club for \$56 a year. Volunteer physicians review 35 leading medical journals and cite what they feel are the most important articles.

The *On-line Journal of Clinical Trials* also charges a subscription fee, but Co-Editor Henry Sacks, M.D., does not believe the fee covers all costs.

How on-line medical journals will produce revenue is uncertain. "The Internet has traditionally been free," says Meyer, "but Web-site sponsors will increasingly want a return for their money and will attempt to require subscriptions." The question is, who is willing to pay?

Some on-line journals have an uncertain future, but as a genre, they are here to stay in part because traditional paper journals are falling behind, according to Patricia Brennan, information services coordinator for the Association of Research Libraries. "Paper journal prices have increased an average of 10 percent every year since 1986," Brennan says. Major medical centers are subscribing to fewer paper journals, even though more are published to handle the growing complexity of research and subspecialties.

Waiting for the Dust to Settle

On-line medical publishing may not replace paper publishing, but it will change how physicians obtain information and communicate with one another. Eventually, the dust will settle, and a peer review and quality hierarchy will take shape. The Wild West of cyberspace may look chaotic, but the innovations this new frontier promises should be well worth the trip.

MM

Howard Bell is a free-lance writer living in Onalaska, Wisconsin.



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ANNOUNCEMENTS

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MMA OFFERS TELEPHONE COLLECTION AND RECEPTIONIST WORKSHOPS

The Minnesota Medical Association and Allied Interstate, Inc., will present workshops for accounts receivable, business office, and point-of-service personnel November 14 at the Radisson Suite Hotel in St. Cloud.

Effective Telephone Collection Workshop

9 a.m. to 12:30 p.m.

Highlights include:

- Seven steps to a successful collection call;
- Telephone do's and don'ts;
- Ways to handle common situations.

Point-of-Service Receptionist Workshop

1 p.m. to 4 p.m.

Highlights include:

- Telephone techniques;
- Seven-step method of quality service;
- Ways to handle complaints and angry clients.

The registration fee is \$75 per person/per workshop. For more information, call Vicki Westling at the MMA, 612/362-3764 or 800/999-1875.

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NEW MINNESOTA PHYSICIANS FOUNDATION BOARD OF DIRECTORS/PRESIDENT ELECTED

The Minnesota Physicians Foundation corporate body elected the following physicians to the MPF Board of Directors: Diane S. Tanabe, M.D., East Metro; Allen W. Delzell, M.D., West Metro; and Richard K. Simmons, M.D., West Metro. Richard B. Tompkins, M.D., was reelected by the MPF Board of Directors as president of the foundation to serve a one-year term beginning January 1, 1997.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

MMA Sets Policy at 143rd Annual Meeting

At the MMA's 143rd Annual Meeting in Brooklyn Park, September 18 to 20, the MMA House of Delegates took action on 60 resolutions setting MMA policy for the coming year. Resolutions covered a wide range of topics from legislative and scope-of-practice issues to public health initiatives.

Two Percent Tax

Replacing the 2 percent tax on health care providers' gross revenues will be a top priority for the MMA in 1997. During the Annual Meeting, the MMA Board of Trustees voted to introduce legislation to phase out the 2 percent tax over a three-year period, reducing it to 1 percent beginning July 1, 1997. In addition, the MMA House of Delegates adopted a resolution that calls on the MMA to introduce legislation that would replace the 2 percent provider tax with other funding sources for the MinnesotaCare program, such as higher tobacco, alcohol, or income taxes.

The MMA has long-standing policy supporting access to health care for all Minnesotans and stating that there should be broad-based funding for the MinnesotaCare program, which provides affordable health insurance for the state's low-income workers. Previous attempts to replace the 2 percent tax with a broad-based tax have met with little success, but this time it might be different. The \$330 million surplus in the Health Care Access Fund makes 1997 the right time to make an all-out effort to replace the tax, accord-

ing to David Renner, MMA director of policy and legislation. "If we don't come up with a plan to spend it, someone else will," Renner told the MMA Board of Directors during the Annual Meeting.

Renner's prediction has proven correct. The Finance Work Group of the Minnesota Health Care Commission is floating a controversial proposal to take \$22 million from the Health Care Access Fund for MCHA, the Minnesota Comprehensive Health Association, a state insurance program for people who have been denied insurance coverage. The work group will make its official recommendations and the commission will vote on them at its November 12 meeting. The MMA strongly opposes using the money in the Health Care Access Fund for any purpose other than the MinnesotaCare program.

The MMA House of Delegates considered another problem related to the 2 percent tax—the pass-through. Currently, there is no way to verify that the tax has been passed through to the health plans, as the authors of the MinnesotaCare legislation intended. The 2 percent tax is often buried in the fees that physicians negotiate with the health plans. The MMA House referred to the MMA Board of Directors a resolution calling for a task force to study the entire methodology of the tax collection, pass-through, and reimbursement and to make recommendations that could include introduc-

Policy continued on page 35



Viewpoint

• • •

Raymond G. Christensen, M.D.
President, Minnesota Medical Association

How Important Is Your MMA Membership?

As the Minnesota Medical Association enters its 143rd year of representing Minnesota physicians, I look forward to serving as your president and deserving the trust you have placed in me.

The MMA is devoted to protecting your interests and serving your needs. We want you to realize the full value of your MMA dues dollar. Membership is the nuts and bolts of our organization. We need your support and participation.

We all value our county and specialty societies, but approximately 80 percent of the major issues of our specialties are issues that are important to the entire house of medicine. We need organizational structure and strength to handle them properly. The MMA provides that structure.

Let's consider how MMA policy is developed.

Who Are the Players?

- You. Grassroots support from MMA members and county medical societies is essential to MMA success.

- The MMA works closely with the county medical societies so ideas generated in these forums flow freely to the MMA.

- Delegates to the MMA House of Delegates develop policy at the Annual Meeting.

- MMA committees and task

forces provide a forum for you to participate in the policymaking process.

- MMA officers and members of the MMA Board of Trustees are dedicated physicians who freely give their personal time to prepare for and attend meetings and develop policy.

- Our AMA delegation represents the Minnesota position in the national house of medicine.

How Does the MMA Decide on Policy?

Before the MMA takes a position, we research the issues, identify the pros and cons, consider the legal ramifications, deliberate, debate, decide whether compromise is possible, and work toward a solution. It's a complex process. Often I have felt confined by my own experiences. But through the careful deliberation and honest exchange of ideas that occurs in our house of medicine, I have reached a clearer understanding.

I would like to point out a hidden gem that makes the MMA function—the MMA staff. As a member of many MMA committees, I have been aware of the value of staff in helping me define and articulate the issues.

Our MMA staff function as our eyes and ears, attuned to the needs of our membership and aware of the mood of the Legislature and the community. Staff exhort and encourage us as we serve in leadership roles and help us navigate our way through the

decision-making process. They help us define the issues, evaluate information, assess the political costs, and determine the risks we are willing to take. Our skilled and dedicated staff truly enjoy working with physicians and they are essential to our success. We must continue to allow for their professional development.

The MMA staff, led by chief executive officer Paul S. Sanders, M.D., are organized into four departments: communications and outreach, legal affairs, legislation and public policy, and membership and administrative services. I encourage you to get to know them. Visit the staff directory on the MMA home page: www.mnmed.org

Why Renew Your Membership?

The MMA has a history of success in representing your interests and serving your needs. Last year, the MMA added a seven-year statute of limitations to the Medical Practices Act, defeated the chiropractors' attempt to win authorization to perform truckers' exams, tightened a law restricting children's access to firearms, helped win federal antitrust relief, continued our campaign against violence, and offered you seminars and continuing medical education opportunities.

Currently, the MMA is mounting an all-out effort to repeal or modify the 2 percent tax, gearing up for renewed battles over scope of practice, fighting to protect children from tobacco addiction, and addressing a host of other issues. We need you.

Your dues buy you an opportunity to join with your professional colleagues—to share your thoughts and feelings, your leadership, and your assistance—as we work for a healthy Minnesota and a strong medical profession. *You*, together with the other MMA members, officers, trustees, AMA delegation, and MMA staff, form the bright and beautiful mosaic of our association.

Safe journeys, and may good health accompany you. • • • • •

Policy continued from page 33

ing legislation during the 1997 session or filing a lawsuit on behalf of Minnesota physicians.

Tobacco Addiction

The MMA will call on the AMA to lobby Congress for a federal law that would force tobacco companies to reduce the nicotine in tobacco products to zero over a six-year period and would require them to indicate the nicotine content on the product's label in "easily understandable and meaningful" language.

In addition, the MMA resolved to publish, at the MMA Board of Trustees' discretion, the names of legislators who vote against Smoke-Free 2000 Coalition proposals and to give this information to MEDPAC to use in deciding on candidate endorsements. "Sometimes you have to play hardball," said Richard K. Simmons, M.D. "We should expose legislators to glaring light if they are collaborating with tobacco companies."

Stop the Violence

The MMA reaffirmed its commitment to the "Stop the Violence" Campaign and adopted several specific resolutions to prevent violence. The MMA will work with other organizations to raise public awareness of shaken-baby syndrome and will call on the AMA to take the same action at the national level. In addition, the MMA supported placing a children's impact statement, such as the one developed by the National Institute on Media and the Family, on video cassettes. The statements indicate the violence level and age appropriateness of the video. "This is not censorship," said Timothy J. Crimmins, M.D., chair of the MMA Board of Trustees. "It allows you to be a better judge of the materials you expose your family to."

See pages 37 to 40 for a summary of the House of Delegates' actions.

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MMA Presents Its Highest Award to Drs. Stolee and Tompkins



Thomas A. Stolee, M.D.



Richard B. Tompkins, M.D.

Thomas A. Stolee, M.D., of Duluth and Richard B. Tompkins, M.D., of Rochester were presented the Distinguished Service Award, the highest award given by the Minnesota Medical Association, at the President's Inaugural Dinner September 19 during the MMA Annual Meeting. The MMA honored them for their years of leadership and service in the MMA and for their outstanding contributions to medicine.

Stolee, who is board certified in pathology and in quality assurance and utilization review, practices at Arrowhead Pathologists in Duluth, chairs the Department of Pathology at Miller-Dwan Medical Center, and is a member of the board of directors of the Northern Lakes Health Care Consortium. A past president of the MMA, Stolee has served on the MMA Board of Trustees, as an alternate delegate to the American Medical Association House of Delegates, and as an MMA and an AMA Hospital Medical Staff Section delegate. He is a past chair of the MMA Hospital Medical Staff Section. Stolee is a past president of the Lake Superior Medical Society, the Minnesota Society of Clinical Pathologists, and the Lake Superior Pathology Society, and he is the past chair of the board of directors of the Foundation for

Health Care Evaluation.

Tompkins, who is board certified in internal medicine and rheumatology, is a consultant in internal medicine at the Mayo Clinic in Rochester, an instructor at the Mayo Graduate School of Medicine, and an assistant professor of medicine at the Mayo Medical School. A past president of the MMA, Tompkins is currently a delegate to the AMA House of Delegates.

Tompkins has served as a member and president of the Minnesota Board of Medical Examiners and as president of the Minnesota Physicians Philanthropic Foundation. He has been a member of the board of directors of the Foundation for Health Care Evaluation and has served as its secretary treasurer and as a member of its executive committee.

A former member of the Health Care Financing Administration's Advisory Committee on Medicare, Physician Relationships, Tompkins currently chairs the Practicing Physicians Advisory Council for the secretary of Health and Human Services.

Tompkins has served as president, secretary, and a member of the executive committee of the Zumbro Valley Medical Society. • • • • •

Informed Consent Is Required for HIV Testing

After much debate, the MMA House of Delegates adopted a resolution to "support a standard of medical practice that would approach HIV like other infectious agents and AIDS like other infectious diseases."

Arguing against this resolution, Sally Trippel, M.D., of the Mayo Clinic, said, "HIV is not like other sexually transmitted diseases. It is universally fatal and it has tremendous implications for the patient, the family, and society."

Several delegates stressed the importance of counseling and gaining the patient's informed consent before testing for HIV. Others pointed out that this resolution would not end the practice of counseling patients or gaining their consent before HIV testing.

But the media coverage was highly misleading. The headline of an

article in the Twin Cities-based *Star Tribune* read, "Doctors support routine testing for HIV." The article went on to say that the MMA vote on this resolution changed the practice of requiring consent forms and counseling. An editorial in the *Star Tribune* interpreted the resolution to mean that the MMA had recommended mandatory HIV testing for pregnant women—with or without their consent. In fact, the resolution does not mention HIV testing, consent forms, counseling, or pregnant women.

MMA Policy

MMA policy on HIV testing remains unchanged.

- Patients should give their consent to HIV testing before it is performed. Consent must be informed, knowing, and voluntary.

- The MMA supports the routine offering of the HIV test to all pregnant women.

Legal Risk

Testing for HIV without a patient's consent could pose a serious legal risk, according to Patricia Franklin, MMA director of legal affairs. Although there is no specific Minnesota statute requiring informed consent before HIV testing, it is generally accepted that, under the current standard of care and case law interpreting the doctrine of informed consent, a test for the HIV antibody should not be done without the patient's consent. • • • • •

Congress Votes to Ban Enforcement of Medical Procedure Patents

In a victory for a coalition of national medical societies, including the American Medical Association and the American Society of Cataract Surgery, Congress passed legislation banning the enforcement of medical procedure patents against physicians. Medical procedure patents confer ownership of medical and surgical procedures such as certain types of surgical incisions. About 100 of these patents are issued every month. The AMA argued that medical procedure patents are unethical because they interfere with the medical community's open exchange of information and they discourage physicians from using some procedures for fear of infringing on a patent. The new legislation bans the filing of infringement suits against medical practitioners for performing a medical or surgical procedure. Sponsored by Rep. Greg Ganske, M.D., R-Iowa, Sen. Bill Frist, M.D., R-Tenn., and Sen. Judd Gregg, R-N.H., the provision passed in the FY '97 omnibus spending bill. It replaces a one-year ban on the issuance of medical procedure patents adopted by Congress in July. • • • • •

Stop the Violence Day at the Dome



In a pregame ceremony on September 29 for "Stop the Violence Day at the Dome," Raymond G. Christensen, M.D., the newly inaugurated MMA president, presented an MMA award to Attorney General Hubert H. Humphrey III for his partnership with the MMA in violence prevention activities. The MMA and the attorney general also presented an award to the Minnesota Twins for their cooperation and help.

1996 House of Delegates Adopts Resolutions at Annual Meeting

The 1996 Minnesota Medical Association House of Delegates convened in Brooklyn Park September 18 and 19 and adopted resolutions that will set the MMA's course for the coming year.

Res. 1, Investigation of Birth Defects and Anomalies in Frogs

Adopted as amended.

The MMA will support scientific efforts to investigate the causes of anomalies in frogs and their possible relationship to human birth defects and will work to reduce the biologic impact of etiologic agents.

Res. 2, Edward Purcell Award

Adopted as amended.

The MMA may award to a young physician in each trustee district the Edward Purcell, M.D., Award for Community Service.

Substitute Res. 3, Tobacco Addiction

Adopted.

See page 35.

Res. 4, Continuing Medical Education Mission Statement

Adopted.

The MMA adopted the following CME mission statement: "To accredit, promote, and assist intrastate CME programs and to provide CME activities that assist physicians in attaining and maintaining high standards of patient care and professional performance."

Res. 5, Chiropractic Scope of Practice

Adopted as amended.

The MMA reaffirms its position that performing a comprehensive physical examination is outside the scope of chiropractic practice in Minnesota. The MMA will lobby to limit the performance of such exams to physicians and will ask the AMA to support similar federal legislation or administrative action.

Res. 6, Exclusive Contracts

Adopted.

The MMA will work to extend the current law prohibiting exclusive contracts.

Res. 7, Role of Advanced Practice Nurses

Adopted as amended.

The MMA supports the task force that is studying issues related to the scope of practice of advanced practice nurses, and the MMA will continue to work with other organizations to develop recommendations.

Res. 8, Emeritus Physician Advisory Committee

Not adopted.

Resolved that the MMA require physicians to step down from the position of MMA trustee, officer, or AMA delegate when they leave active medical practice and further resolved that the MMA establish an emeritus advisory committee.

Res. 9, Access to Tobacco

Adopted.

The MMA endorses the Minnesota Hospital and Healthcare Partnership's program "STAT" (Stop Teen Access to Tobacco) and will encourage MMA members to support ordinances to reduce youth access to tobacco. Furthermore, the MMA will support state legislation to reduce children's access to tobacco and preserve cities' ability to make access even more difficult.

Res. 10, Anti-Smoking Legislation

Adopted as amended.

See page 35.

Res. 11, Complementary Medicine

Adopted as amended.

The MMA will ask clinical research organizations to base their study of complementary and alternative health care on evidence-based

standards such as those used by the U.S. Preventive Services Task Force. The MMA will educate members and the public on these studies' outcomes.

Res. 12, Personnel in Non-acute Health Care Settings

Referred to the Board for study.

Resolves that the MMA work with other groups to develop educational programs on the appropriate functions of all licensed health care professionals in non-acute health care settings, such as clinics and physician offices. Programs and materials should address issues such as the supervision of delegated medical functions, nursing functions, and administrative tasks.

Res. 13, Principles of Collaboration

Amended and referred to the MMA Board of Trustees for study.

Resolves that the MMA support a process that would lead to further understanding and collaboration among physicians and medical organizations including, but not restricted to, the following issues: contracting standards, physician credentialing standards, physician performance evaluation criteria, data collection and analysis processes and methodologies for the evaluation of physicians' performance, affiliation/disaffiliation procedures, due process and mediation procedures, and input into CPT and ICD-9 coding.

Res. 14, Animal Research

Adopted as amended.

The MMA will develop and disseminate a position statement supporting appropriate and necessary animal research and will develop a public education program. The MMA will ask the AMA to expand its public education program for animal research.

Res. 15, Terms to Describe Medical Care Processes

Not adopted.

Resolved that the MMA ask the AMA to study the use of terms to

Resolutions continued on page 38

Resolutions continued from page 37

describe common medical care processes and recommend standard terms.

Res. 16, Health Care Financing Administration (HCFA) Guidelines Referred to the MMA Board of Trustees for study.

Resolves that the MMA communicate to HCFA its strong opinion that repetition of a pelvic exam performed by an experienced resident, purely for purposes of allowing staff billing, represents an assault on patient modesty and privacy and thwarts ascending levels of resident responsibility. The MMA should work with other organizations to seek changes in HCFA rules.

Res. 17, HIV and AIDS

Adopted as amended.

See page 36.

Res. 18, Seat Belt Safety

Not adopted.

Resolved that the MMA support legislation that would increase the fine for failure to wear a seat belt and would treat this offense as a moving violation.

Res. 19, Protective Headgear for Minors While Skiing and Snow Boarding

Referred to the MMA Board of Trustees for study.

Resolves that the MMA support legislation that would require minors to use protective headgear while skiing and snow boarding in licensed Alpine ski areas.

Res. 20, Protective Headgear For Minors While Bike Riding, Using ATVs and Snowmobiles

Not adopted.

Resolved that the MMA support legislation that would require minors to use protective headgear while operating bicycles, ATVs, and snowmobiles.

Res. 21, Water Safety

Not adopted.

Resolved that the MMA support legislation to require all minor children to use flotation devices while underway in unnavigable waters in Minnesota.

Res. 22, Parent Education

Adopted.

The MMA will encourage all new parents to participate in parent education classes and will encourage health systems to provide parent education for their clients.

Res. 23, Preventive Services Principles

Adopted as amended.

The MMA endorses the following statement based on U.S. Preventive Services Task Force principles:

- Interventions that address patients' personal health practices are vitally important.
- Physicians and patients should share decision-making.
- Physicians should be selective in ordering tests and providing preventive services of unproven effectiveness.
- Physicians should take every opportunity to deliver appropriate, effective preventive services, especially to persons with limited access to care.
- For some health problems, community-level interventions may be more effective than clinical preventive services.

Res. 24, Evidence-Based Care

Adopted as amended.

The MMA endorses the use of evidentiary, scientific standards, such as those used by the U.S. Preventive Services Task Force, in making health care decisions, and when considering proposed legislative initiatives to mandate standards of care.

Res. 25, High-Risk Pregnancy Assessment

Adopted as amended.

The MMA will endorse the implementation and use of the uniform Minnesota Pregnancy Assessment Form pending evaluation of pilot test results and approval by the MMA Board of Trustees.

Res. 26, Uniform Credentialing Forms

Adopted as amended.

The MMA endorses the use of uniform credentialing forms by all organizations, including hospitals, that require credentialing information from physicians.

Res. 27, Eligibility to Serve as MMA Officer

Withdrawn.

Resolved that the MMA require physicians to be engaged in active clinical medical practice to be eligible for election as an MMA officer, trustee, or AMA delegate.

Res. 28, WHO Recommendation for Infant Mortality Rate

Adopted.

The MMA will call on the AMA to create a task force to work with the National Center for Health Statistics and the state statistics units to create a reporting format for the infant mortality rate that incorporates World Health Organization recommendations and is comparable to the reporting format used in other developed countries so that comparisons of IMR among countries will be accurate.

Res. 29, Reporting HMO Financial Information

Adopted as amended.

The MMA will determine the feasibility of annually reporting information, including the following: 1) reserves of HMOs, health management companies, hospital systems, and PPOs; 2) total compensation for leaders and board members of these organizations; and 3) the relationship of compensation and retained earnings to premium charges.

Res. 30, Substitution of Cigarette Tax for 2 Percent Tax

Adopted as amended.

See page 33.

Res. 31, Defining "Medical Necessity"

Referred to the Board of Trustees for study.

Resolves that the MMA convene

a forum of providers and payers to define "medical necessity" and agree on the uniform application of the term. If the forum fails to reach agreement, the MMA should strongly consider seeking a definitive court ruling on the term and should call on the AMA to do the same at the national level.

Res. 32, Section for Employed Physicians

Not adopted.

Resolved that the MMA consider establishing a section for employed physicians.

Res. 33, Member Ombudsman

Adopted as amended.

The MMA will study the possibility of providing information and services to MMA members who are facing regulatory and contractual problems or who have other concerns with the Minnesota Board of Medical Practice, the health plans, employers, the Minnesota departments of Human Services and of Health, and other state and federal agencies. The Minnesota Physicians' Foundation will evaluate the need to provide support services to physicians facing such problems.

Res. 34, Study Premiums for Point-of-Service Products

Referred to the MMA Board of Trustees for study.

Resolves that the MMA study health plans' point-of-service filings and the effect of the point-of-service premium rates on enrollees' use of products and on providers, and publish a report of its findings and recommendations for further regulatory and/or legislative actions.

Res. 35, Eliminating Special State Requirements for Medical Licenses

Adopted the first resolve as amended.

The MMA will work with the AMA and the Federation of State Medical Boards to standardize continuing medical education requirements and consider eliminating other special requirements that create

barriers for physicians seeking licensure in several states.

Referred the second resolve to the Board of Trustees for study.

Resolves that the MMA work with the BMP to seek legislation that would define utilization review as the practice of medicine.

Res. 36, Reimbursement of the 2 Percent Provider Tax

Referred to the MMA Board of Trustees for decision.

See page 33.

Res. 37, Section for Self-Employed Physicians

Not adopted.

Resolved that the MMA consider establishing a section for self-employed physicians by May 1997.

Res. 38, Permits to Carry a Concealed Weapon

Adopted.

The MMA supports the recommendation of the Minnesota chiefs of police that issuing permits to carry a concealed weapon should remain at the discretion of local law enforcement agencies.

Res. 39, Racial and Ethnic Disparities in Health Care

Adopted as amended.

The MMA commends the AMA's efforts to alleviate the disparities in care to minority populations and resolves to oppose racially or culturally based disparities in health care in Minnesota. The MMA will support initiatives to alleviate such disparities.

Res. 40, Physician-Assisted Suicide

Adopted as amended.

The MMA will work to educate the public and health care professionals about the significant difference between the decision to limit medical treatments and to actively assist suicide. The MMA reaffirms its policy opposing assisted suicide.

Res. 41, Environmental Protection

Adopted as amended.

The MMA acknowledges the efforts of federal and state agencies to protect occupational and environmental health by working with industry and labor.

Res. 42, Screening for Violence

Adopted as amended.

The MMA will continue its Stop the Violence Campaign and will encourage physicians to perform violence prevention screenings.

Res. 43, Nutrition

Adopted.

The MMA supports the Five-a-Day Program, encouraging Americans to eat at least five servings of fruits and vegetables a day. The MMA will help educate physicians and patients about the benefits and goals of the program.

Res. 44, Support Services

Adopted as amended.

The MMA Board of Trustees will recommend to the Minnesota Physicians Foundation that a program be developed to provide support services for Minnesota physicians who are experiencing stress.

Res. 45, Amending the Access to Health Records Statute

Adopted as amended.

The MMA will continue to support legislative efforts to allow medical and scientific researchers to review medical information for research without obtaining the patient's written general authorization, provided reasonable safeguards have been taken to ensure that the research project is valid and important and that patient confidentiality is protected.

Res. 46, Deletion of Section of Board of Nursing Rules

Referred to the MMA Board of Trustees for Study.

Resolves that the MMA support the nurse practitioners' legislative efforts to delete the section in the Minnesota Rules that lists specific drugs that advance practice nurses can prescribe.

Resolutions continued on page 40

Resolutions continued from page 39

Res. 47, MMA Recommendations Concerning Telemedicine

Adopted.

The MMA adopts the recommendations in the Telemedicine Report. See page 52.

Res. 48, Nutrition Education

Adopted as amended.

The MMA will encourage Minnesota's medical schools to ensure that nutrition instruction is adequately covered in their curricula. The MMA will call on the AMA to encourage the National Board of Medical Examiners to ensure that all areas of nutrition and nutritionally related diseases are covered adequately on the U.S. Medical License Examination.

Res. 49, OSHA Ergonomics Rider

Adopted.

The MMA will ask the AMA to work for the repeal of the "Ergonomics Rider" on the Occupational Safety and Health Administration budget, which restricts activities in cumulative trauma disorders prevention.

Res. 50, Alcohol Screening

Adopted as amended.

The MMA will educate Minnesota physicians about the CAGE questionnaire as a screening tool for detecting alcohol abuse.

Res. 51, Laser Surgery

Adopted.

The MMA will support legislative or regulatory action to prohibit the performance of surgery, including laser surgery, by optometrists.

Res. 52, Alcohol Excise Tax

Adopted as amended.

The MMA reaffirms its support for an increase in the alcohol excise tax.

Res. 53, Trauma Care in Minnesota

Adopted as amended.

The MMA adopted the follow-

ing policy statements:

1) The MMA should continue to study state regulations of the minimum standards appropriate to require of trauma systems and hospital trauma services and the minimum standards of training for first responders and emergency medical technicians.

2) The MMA should support the authority of the EMS Regulatory Board to regulate interfacility transfers.

3) The MMA should support state data-gathering initiatives regarding the state of trauma care in Minnesota.

4) The MMA should promote and study incentives to encourage physicians to become medical directors.

Res. 54, Reimbursement for Midlevel Provider Services

Referred to the MMA Board of Trustees for study.

Resolves that the MMA adopt a policy stating that services provided by midlevel providers under physician supervision should be reimbursed at the same level as those provided by physicians. It further resolves that the MMA should address the issue of health plans discounting reimbursement for services provided by mid-level providers under physician supervision.

Res. 55, Shaken-Baby Syndrome

Adopted.

The MMA will seek partnerships with organizations involved in the diagnosis and prevention of shaken-baby syndrome to educate and raise awareness among the public and the medical community. The MMA will call on the AMA to take the same action at the national level.

Res. 56, Pharmaceutical Manufacturers

Adopted as amended.

The MMA will seek to: 1) work with appropriate groups to ensure that the most cost-effective and efficacious compounds are included in health plan formularies, and 2) develop public education programs to balance public expectations and the

efficacy of the formulary compounds.

Res. 57, Membership Dues

Not adopted.

Resolved that the MMA Board of Trustees reduce its 1997 individual membership dues by no less than 5 percent, with a target reduction of 10 percent.

Res. 58, Commendation for Dayton Hudson Corp.

Adopted.

The MMA will send a letter to the Dayton Hudson Corp. commending its decision to discontinue the sale of tobacco products in Target stores nationwide.

Res. 59, FDA Tobacco Regulations

Adopted as amended.

The MMA strongly supports and endorses the 1996 Food and Drug Administration regulations to reduce children's and adolescents' use of tobacco. The MMA will call on the AMA to adopt similar policy.

Res. 60, Children's Impact Statement on Videos

Adopted as amended.

See page 35. • • • • •

The Monitor

NOVEMBER 1996

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2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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Use of the World Wide Web by Family Practitioners

Kory Tuominen, B.A., and Byron J. Crouse, M.D.

ABSTRACT

We introduced the World Wide Web to family practitioners through seminars conducted at 13 family practice clinics in northern Minnesota. The seminars included the history and applications of the Web. We also conducted searches on the Web with the family practitioners and graded the searches for physician usefulness. The physicians then evaluated the technology through a subjective survey.

Thirty-three searches were attempted with 55% resulting in useful information. The average grade increased 22% over the study period, while the search time decreased 7% to an average of 8.5 minutes per search.

The majority of family practitioners surveyed (65%) said they would use the Web in their practice, primarily for patient education, CME, and information retrieval. The major disadvantage they cited was the length of time to retrieve information.

Our goal was to introduce the professional community to an available technology that may enhance the quality of medical practice and to determine the technology's present and future applications. These preliminary results indicate that health care professionals recognize the practical usefulness of the Web.

In practicing medicine, physicians must continuously attain and disseminate knowledge. The challenge is to do so in the most time- and energy-efficient manner. The introduction of computers into medical practice has already streamlined administrative and scheduling areas but, until recently, has had little effect on the clinical arena. According to a 1994 article in the *Journal of the American Medical Association*, "Computers have become indispensable tools for managing the rapidly growing body of medical information."¹ What better way to disseminate information to the practicing physician than through computers?

However, medical professionals have been hesitant to use the Internet because of its complexity. Even as the technology continues to improve, most physicians are not ready to incorporate it into their practices, possibly because they are reluctant to change from the proven traditional ways of acquiring medical knowledge or because they do not have the time to learn a new system.² Regardless, the possibilities for communication within the health care profession via this medium are enormous and continue to grow daily.

Access to diverse medical databases may be helpful to all caregivers, but family practitioners can benefit the most because they diagnose such a wide variety of illnesses. Still, the World Wide Web (also called the Web) has yet to be evaluated for its usefulness to family practitioners. This study assesses the practicality of the Web (using the browser Netscape) for family practitioners and their practices.

METHODS

We conducted on-site seminars at 13 family practice clinics in northern

Minnesota. These seminars (15 to 30 minutes each) included a brief background on the Internet and the development of the Web and highlighted possible Web applications in medical practice. We demonstrated various uses of the Web, such as retrieving medical information through search engines and medical indexes, educating patients, identifying CME opportunities and courses, and accessing medical databases.

Following the seminar, we used Netscape to retrieve information related directly to patients seen in the respective clinics. Physicians associated with the specific patient or case were able to ask questions that guided what information the facilitator retrieved. We timed the searches and graded their perceived usefulness to the physician. At the close of the on-site visit, participants completed a subjective survey to help us evaluate the perceived usefulness of the World Wide Web. The questionnaire asked the following:

- Do you now use or foresee the use of computers in your practice? If so, in what context?
- Do you see the World Wide Web as being an asset to your practice? Why?
- What do you think are the advantages/disadvantages of this technology?
- If it were possible to use the World Wide Web in your practice, would you? For what applications?

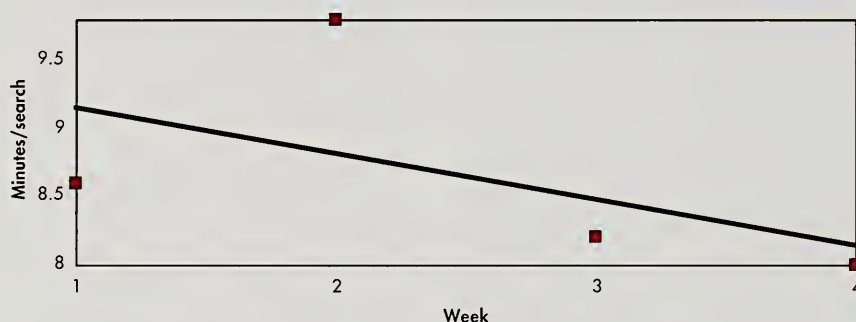
RESULTS

We led active Web searches at 10 of the 13 clinics that held seminars. The number of searches varied from one to six, with an average of 3.3 searches per site. We graded each search on a scale of one (not helpful), two (somewhat useful), or three (very useful). Information was found in only 73%

Figure 1: Weekly Usefulness Ranking of Retrieved Information Using the World Wide Web



Figure 2: Average Time/Search Using the WWW



of the 33 searches attempted, with an average usefulness ranking of 2.1 for the information found. The type of information retrieved ranged from patient education information on lead exposure and low cholesterol diets, to clinical information on abnormal phosphorous levels and lobular breast cancer.

When information was obtained, we ranked it as somewhat to very useful 75% of the time. The weekly average usefulness ranking increased 22% over the four-week study period (see Figure 1). The average time per search decreased 7% over the study period. Searches averaged 8.5 minutes (see Figure 2).

Eighteen physicians filled out closing surveys. The results are shown in the table on page 45. All respondents who returned questionnaires use or foresee using computers in their practice, such as for retrieving business and clinical information. The physicians surveyed expressed interest in using computers for literature searches (44%), patient education (22%), CME (22%), and for obtaining diagnosis and treatment guide-

lines/updates (11%). The majority of physicians (59%) said the Web would be an asset to their practice. More impressive, 65% said they would use the Web in their practice if it were available.

DISCUSSION

Physicians are beginning to realize the potential of the Web. Remarkably, two-thirds of the participants in the study replied that they would use the Web in their practice today if it were available.

Educational and government-funded sites are the most common on the Web, along with privately created and commercially funded sites. Medical sites provide information regarding specialties, diseases, general patient education, continuing medical education, health care data, and much more. (Examples of selected medical sites currently available on the Web are shown on page 19.)

The two main challenges physicians noted in our study are time and the cost of computer equipment. Setting up to use the Web involves significant financial investment. How-

ever, a study on the use of computers among rural Minnesota family physicians conducted during the summer of 1994 showed that 93% already have computers in their office and that 67% of the computers are equipped with a modem (unpublished data, Kolarsky K, Anderson J, UMD School of Medicine). In other words, the necessary hardware is often already in place for accessing the Web.

Time is a significant obstacle. In our study, physicians needed an average of about eight minutes to find "some useful" (≥ 2 rating) information on the Web. Fifty-six percent of the physicians surveyed said a disadvantage of the Web is that it's too slow. Until search time is reduced to three to five minutes, busy physicians will be reluctant to use the Web on a regular basis.

Search times decreased by 7% over the four weeks of our study as familiarity with the Web increased. The learning curve for this technology is very short, especially when compared with older approaches, such as Telnet, which is still in use.³ This was demonstrated by the 22% increase in usefulness of the information found throughout the study period.

Continuing advances in the quality of medical databases and search engines are decreasing search time and making the Web more practical for physicians to use. These improvements are a result of independent and coordinated efforts of government, educational institutions, and commercial companies.⁴

A time-saving option would be for medical support staff to perform information searches, particularly to retrieve patient education information. While support staff can do general searches, the physician may conduct more specific clinical searches. This method uses resources better and increases the practicality of the technology in clinical practice.

Today, the most likely use of the Web would be for patient education and continuing medical education (for more on using the Web, see "Let's Go Surfing! A Physician Guide to the Internet," page 12). Another effective use would be as a medical reference for physicians to retrieve information on uncommon diag-

noses. The uses physicians foresee indicate the breadth of information available.

In our study, 28% of respondents said that a disadvantage of the Web is that it's confusing and requires computer literacy, indicating that many physicians need training. The real challenge is to convince physicians who are not computer literate to invest time in training. Once physicians begin to use the Web, information about advances in medicine will have an immediate effect on the health of individuals or populations.⁵

CONCLUSION

Family practitioners rely heavily on access to information. According to Regennitter et al., the Web can "shrink time, distance, and the cost of information transfer while promoting idea sharing among professional colleagues."⁴

Many computer-literate physicians advocate use of the Web. In the words of one physician who is implementing this technology in his practice, "I see access to the World Wide Web as being too great an advantage to simply dismiss because of the inherent initial difficulties in becoming familiar with its usage."

Opportunities to start "crawling the Web" are available to users at all levels. Beginners can take advantage of community adult education classes. Those with more experience can use manuals on the Web or participate in self-study Web tours. Advanced users can spend time searching medical topics and developing their own index of useful sites.

The Web is the forerunner for the future standard of information retrieval. Health care professionals are challenged to implement this technology in their practice. As the usefulness of the Web increases with improved access to quality medical databases, the shift will become easier. The quality of these sites is directly related to the input of qualified medical professionals. Therefore, sound development of the technology is dependent on involvement of the medical community. Considering that "every new technical advance in communication ... has been adopted by medicine,"² physicians

Table

Summary of closing survey

Do you now use or foresee the use of computers in your practice? If so, how?

Positive responses: 100%

How:

Literature searches	44%
Patient education	22%
CME	22%

Do you see the World Wide Web as being an asset to your practice? Why?

Positive responses: 59%

Negative responses: 41%

Reasons:

Much information	17%
Current information	11%
Easy access	6%
Patient education	6%
Literature review	6%

Reasons:

Info. not easily accessed ...	33%
Time problems	28%
Not developed enough	11%
Unreliable	6%
Technical difficulties	6%

What do you think are the advantages/disadvantages of this technology?

Advantages:

A lot of information	28%
Recent or difficult information retrieval	11%
Resources good	6%
Wide access	6%
Continuing medical education	6%
Aesthetically interesting for patients	6%

Disadvantages:

Too slow	56%
Difficulty in finding specific information	28%
Confusing/need to be computer literate	28%
No set index	11%
No checkmarks of reliability	6%
Too hard to access	6%
Not reliable	6%

If it were possible to use the World Wide Web in your practice, would you? For what applications?

Positive responses: 65%

Reasons:

Patient education	33%
Continuing medical education	17%
Information on unusual illnesses	11%
Current information	11%
Support groups for unusual illnesses	6%
Information on global subjects	6%
Management of chronic disease	6%
New treatments	6%
Literature searches	6%
Recent prescription information	6%

Negative responses: 23%

Reasons:

Wouldn't use on a regular basis	11%
Quicker to use texts	6%
Is in developmental stage	6%
Not time efficient	6%

No response: 12%

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and other health care providers should not hesitate to invest in the Internet, both to improve their practices and, more important, their patients' health. MM

ACKNOWLEDGMENT

We'd like to acknowledge Kate Beattie, research associate, for her work on the preparation of this manuscript.

Kory Tuominen is a medical student at the University of Minnesota. Byron Crouse is head of the Department of Family Medicine at the University of Minnesota-Duluth School of Medicine.

REFERENCES

1. Glowniak J, Bushway M. Computer networks as a medical resource: accessing and using the Internet. JAMA 1994;271(24):1934-9.
2. Lincoln TL. Traveling the new information highway. JAMA 1994;271(24):1955-6.
3. Zelingher J. Exploring the Internet. MD Comput 1995;12(2):100-44.
4. Regennitter FJ, Volz JE. An introduction to the Internet. Am J Orthod Dentofacial Orthop 1995;107(3):339-44.
5. Kassirer JP. The next transformation in the delivery of health care. N Engl J Med 1995;332(1):52-3.

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Protecting the Privacy of Computerized Health Information

The Kassabaum-Kennedy Act

*Concern over unauthorized access to computerized medical information
has spurred a new federal law to protect patient privacy.*

Mary Prentnieks, J.D., M.P.H., and Shirley Qual, J.D.

When state officials uncovered evidence of Mafia infiltration into the health care industry in New Jersey last August, they said the "Mob's entry into the nation's rapidly expanding field of group care poses an ominous threat," according to the *New York Times*. Investigators warned that "the medical industry was a potential treasure-trove for mobsters who could use sensitive and personal information gleaned from group-care programs to blackmail and exploit patients and health care providers." Although there was reportedly no evidence of such misuse of records in the case, the deputy chief of the state-organized Crime Bureau, Robert T. Buccino, noted that the Mafia "did have access to medical records, and [they] could be used for extortion and other criminal purposes."

Confidentiality of medical records has always been an issue in the health care industry. Data privacy concerns are heightened as the industry computerizes medical records and increasingly uses electronic communication systems to transmit health care data. Based on stories about electronic communications in general, there is real cause for concern. According to a recent Twin Cities-based *Star Tribune* article, Internet hackers infiltrated the U.S. Justice Department's official home page, altering it to include swastikas, sexually explicit pictures, and criticism of the Communications Decency Act. Upon discovering the hacker's work, government

technicians turned off the World Wide Web site only to discover that the hackers had changed the department's site to read, "United States Department of Injustice."

PRIVACY WITH A NEW FACE

The shift to computerized data systems raises new challenges in preserving patient privacy and confidentiality and ensuring security of health information.* According to Deirdre Mulligan, staff counsel at the Center for Democracy and Technology in Washington, D.C., "The traditional paper environment inherently provides some protection of privacy due to the physical boundaries that exist, i.e., file cabinets, locks, doors, and location of the paper record. While constraints of this paper world may impede some necessary and desirable information sharing, they also, by default, provide a deterrent to prying eyes and inquisitive minds."

*The former Office of Technology and Assessment defined privacy as the right of an individual to limit access to information regarding that individual and defined confidentiality as a form of informational privacy characterized by a special relationship between people, such as the relationship between doctor and patient. Security was defined as technical and organizational procedures that protect electronic information and data processing systems from unauthorized access, modification, destruction, or misuse.

A networked environment, on the other hand, creates difficulties that may lead to breaches in privacy. "Individuals are concerned that health information may be reused or sold for purposes other than that for what it was provided, that computers are increasing errors in medical records and facilitating the propagation of errors at lightening speed, that automation is allowing unauthorized individuals to access their personal health records, or that health information is being compiled with other information about their finances, education, and employment and may be used in ways that harm their lifetime opportunities," says Mulligan.

Nevertheless, Mulligan emphasizes that computerized medical information may offer some unique opportunities for privacy protection. "Electronic systems are capable of limiting access at a level difficult in a paper environment," she says. For example, information systems can limit access to various data elements or sections of a patient's medical record based on who is seeking the information (doctor, claims processor, or administrator) and on the patient's individually tailored decisions to grant or limit access. Audit trails can provide a continuous log of information about system activity, including the user's identity (both at the institutional and user level), the date and time the user obtained information, the information accessed, and the function performed (e.g., read, copy, edit, delete). This can

greatly increase recordkeepers' ability to identify misuse and unauthorized access to data, as well as to assure accuracy. In addition, cryptography, the practice of scrambling information using a mathematical technique to ensure it is only accessible to those with permission, can greatly increase the security of information during both transit and storage, says Mulligan.

PUBLIC ATTITUDES

A 1995 Equifax-Harris Consumer Privacy study found that the vast majority of Americans see the trend toward a computer-based patient record system as either "very beneficial" (40 percent) or "somewhat beneficial" (45 percent), even though 80 percent of respondents believed consumers have "lost all control over how personal information about them is circulated and used by companies." It may be that most consum-

ers have resigned themselves to the loss of privacy. Or maybe consumers feel the computerization of patient medical records has personal benefit to them. For instance, the Equifax survey revealed that 86 percent of those surveyed agreed it would be "very important" to have a computerized medical patient record that can provide key medical information in an emergency when they are away from home. When reporting concern about computerized medical records, most people said they were either "very concerned" (33 percent) or "somewhat concerned" (41 percent) about the potential negative effects of such a system.

Consumers agree that health care costs need to be held down. A computerized medical record system may streamline paperwork and speed billing and other claims handling administrative functions, which most consumers agree are valuable out-

comes. In the Equifax survey, more than seven in 10 people said a variety of quality and cost benefits provided by a computer-based patient record system would be "very important" to them. Further, the respondents felt that more important than privacy protection were controlling the cost of medical insurance, staying out of excessive debt, reducing insurance fraud, and controlling the cost of false advertising. The public seems willing to accept privacy risks, as long as computerized records result in personal benefits, improved quality of care, and reduced costs.

CALL FOR FEDERAL ACTION

Minnesota has passed a variety of laws to protect patient privacy and prevent the misuse of health care data. However, the consensus at the national level favors federal law that overrides such state statutes. The National Academy of Sciences Insti-

HIGHLIGHTS OF THE KASSABAUM-KENNEDY ACT

PRIVACY

The Kassabaum-Kennedy Act requires the secretary of Health and Human Services to submit to Congress detailed recommendations on standards with respect to the privacy of individual health information. At a minimum, the recommendations must address the rights of individuals, the procedures that should be established to exercise such rights, and the uses and disclosures of authorized or required information.

If Congress fails to enact legislation within 36 months after the law goes into effect, the secretary of Health and Human Services must promulgate final regulations within the following six months. The regulations will not preempt contrary but more stringent state laws.

ADMINISTRATIVE SIMPLIFICATION

The new law also requires health plans, health care clearinghouses, and providers who transmit electronic health information to maintain reasonable and appropriate administrative, technical, and physical safeguards that ensure the integrity and confidentiality of the information; to protect against any reasonably anticipated threats or hazards to the security or integrity of the information and unautho-

rized uses or disclosures; and otherwise to ensure compliance with the law.

This section of the act requires adopting standards for financial and administrative electronic information transactions. The types of transactions addressed include those for health claims or encounter information, claims attachments, enrollment and disenrollment information, health plan eligibility, payment and remittance advice, plan premium payments, first report of injury, health claim status, referral certification and authorization, and others as determined appropriate by the secretary of Health and Human Services. This portion of the law supersedes any contrary state laws, including those that require health records and billing information to be maintained or transmitted in written rather than electronic form, except under certain circumstances.

In adopting standards, the secretary of Health and Human Services will:

- create unique health identifiers for individuals, employers, plans, and providers;
- select code sets for appropriate data elements from among already developed code sets, or establish code sets if none have been developed;
- develop security measures that take into account technical capabilities of health record systems,

tute of Medicine (NASIM) has recommended that Congress enact federal legislation that establishes a uniform requirement for assuring confidentiality and protecting privacy rights related to individual health data. Its proposal includes a Code of Fair Health Information Practices to ensure a proper balance among required disclosures, use of data, and patient privacy.

In a recent *Journal of the American Medical Association* article discussing proposed federal legislation, Lawrence O. Gostin, associate professor of law at Georgetown University Law Center in Washington, D.C., argues for a strong preemptive federal statute to deal realistically with the issue of privacy of medical records. "It doesn't have to be total but it should be substantial." Gostin goes on to say, "A state-by-state approach to health information does not work. The physical location of a medical

record is not relevant when information is rarely restricted to the state in which it is generated. Such information is routinely transmitted to other states that may have different legal requirements for a wide variety of purposes, from public health surveillance to medical consultation to government financing."

Gostin acknowledges the argument that federal law may be weaker than certain state laws, resulting in less protection. However, without federal preemption, he says, laws will vary from state to state, which may impose barriers to transmitting information across state lines and cause confusion. The integrity of data may be adversely affected.

Kathleen Frawley, director of the Washington, D.C., office of the American Health Information Management Association, agrees. "Clearly, efforts must be directed toward developing national standards on

privacy and confidentiality." Even before federal law was enacted, Frawley recommended that health care organizations take steps to develop effective information security management programs to ensure confidentiality of health information.

In testimony submitted to the U.S. Senate Committee on Labor and Human Resources, Janlori Goldman, deputy director of the Center for Democracy and Technology, said, "Relegating the protection of health care information to the states' different guidelines, policies, and laws leaves individuals subject to differing degrees of privacy depending upon where they receive their health care."

She pointed out several concerns. "In some instances, this means that individuals traveling across county or state lines to receive necessary medical treatment may lose their ability to control how their personal

costs of security measures, the need for training persons who have access to health information, the value of audit trails in computerized record systems, and the needs and capabilities of small health care and rural providers;

- specify procedures for the electronic transmission and authentication of signatures for financial and administrative transactions; and
- adopt standards for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

The secretary must adopt the above standards within 18 months after the law goes into effect. Standards relating to claims attachments must be adopted within 30 months.

CIVIL AND CRIMINAL SANCTIONS

Noncompliance with the law may result in civil penalties of up to \$100 for each violation. The total amount imposed for all violations of an identical requirement cannot exceed more than \$25,000 per year. Civil penalties may not be imposed if an act is punishable under the criminal penalties provisions or if the secretary of Health and Human Services is

satisfied that the person did not know and, by exercising reasonable diligence, would not have known of a violation. In addition, the penalties do not apply if failure to comply is due to reasonable cause and not to willful neglect, provided the failure to comply is corrected within 30 days of when the person knew or would have known that the failure to comply occurred. The secretary may extend the time period for correction and may provide technical assistance to a person who was unable to comply.

Criminal sanctions may be imposed for wrongful disclosure of individually identifiable data. A person who knowingly and in violation of the law uses a unique health identifier, obtains health information relating to an individual, or discloses individually identifiable health information to another person will be punished with a fine of up to \$50,000, imprisoned for not more than one year, or both. If the offense is committed under false pretenses, the violator may be fined up to \$100,000, imprisoned up to five years, or both. If the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, the maximum fine increases to \$250,000 and maximum imprisonment to 10 years.

—MP & SQ

medical information is used. Moreover, states and local governments with different rules governing the use of health care information may be prevented from sharing health care information contained in their systems with neighboring states that insufficiently protect privacy."

Not surprisingly, recent federal legislation has addressed these concerns.

FEDERAL RESPONSE: THE KASSABAUM-KENNEDY ACT

The Kassabaum-Kennedy Health Insurance Portability and Accountability Act of 1996 has significantly raised the stakes for mishandling health care information (see the sidebar, page 48, for a summary of the act). Although news accounts have focused on the health benefits this new law affords, such as portability of coverage and preexisting condition limitations, the law also contains sweeping federal privacy and security oversight measures, including mandates for standards and steep federal criminal sanctions to enforce compliance. Implementation of these measures remains uncertain and will be worked out when future standards are developed and adopted.

The Center for Democracy and Technology's Mulligan feels the new legislation fails to provide comprehensive patient data privacy protections at the front-end. Rather, the legislation will implement regulations for the electronic exchange of information before standards to protect patient privacy are developed. According to Mulligan, "That is putting the cart before the horse. The good news is that for the first time there will be some federal policy. The bad news is that we don't know what it will look like." She and others advocating for patient data privacy protections at the federal level hope that the secretary of Health and Human Services, who plays a key role in adopting the standards, will consider the work that has been accomplished over the past few years.

STATE IMPACT

Two general areas of the Kassabaum-Kennedy Act will eventually impact

Minnesota law. The act mandates adopting standards to protect patient privacy as well as to heighten security measures and streamline transactions between health care providers and payers. The privacy standards must address individual rights to privacy of health information; procedures to protect those rights; and the uses, disclosures, and need for authorization.

These privacy standards will likely have far-reaching ramifications for states currently without strong patient privacy protection measures, but they will not preempt stronger state laws. Since Minnesota already has several strong laws, the federal law may not have as dramatic an impact here as in other states. Nevertheless, a full analysis and comparison of the new federal privacy standards with current state laws will be needed to ensure compliance with both. Close scrutiny is imperative because anyone handling health care data will now be exposed to federal prosecution that could involve large monetary penalties and imprisonment.

Once developed, security standards should provide clarity and consistency for the industry. With some exceptions, these new security standards will supersede any contrary state laws, including those that require health records to be maintained or transmitted in written rather than electronic form. As a result, the Minnesota Department of Health has delayed adopting potentially conflicting state standards, such as those regarding unique health identifiers.

LIABILITY

In Minnesota, the negligent or intentional release of health records without the consent of a patient may result in liability. Various Minnesota laws address medical records release, including the Minnesota Government Data Practices Act, the Minnesota Insurance Fair Information Reporting Act, and the Minnesota Access to Medical Records Act. In addition, the 1995 Legislature enacted a law to strengthen privacy protections and security measures for data submitted to the Minnesota Department of

Health and the Minnesota Health Data Institute.[†] Electronic communications flowing from one industry participant to another were exempted from the 1995 revisions and were subjected to patient privacy protections already existing in law. The Kassabaum-Kennedy Act will now apply to the communications of providers, health plans, and health care clearinghouses.[‡]

National standard-setting organizations have developed security guidelines for electronic information systems. In Minnesota, a security workgroup of MedNet, a nonproprietary electronic health information network under the Minnesota Health Data Institute, recently developed a security policy document with recommendations for using and securing the MedNet network. In the document, the institute recommends that each organization using MedNet establish a security officer position responsible for setting up appropriate security measures. In addition, the institute recommends specific security measures, such as the installation of "fire walls," computer hardware and software that block unauthorized communications between an institution's network and external networks. The document also provides a sample security policy for participants to use while drafting their own. Participants of MedNet are encouraged to review the document and implement those recommendations appropriate to their operations.

Following closely the recommendations of standard-setting organizations strengthens an organization's or person's defense if sued for inad-

[†]For a more in-depth discussion of Minnesota laws protecting patient data submitted to the health department and the data institute, see "Data Privacy Under MinnesotaCare" in the October 1995 *Minnesota Medicine*, pages 47-51.

[‡]Under the Kassabaum-Kennedy Act, a health care clearinghouse is defined as a public or private entity that processes or facilitates the processing of nonstandard data elements of health information into standard data elements.

vertently releasing information. Once standards are proposed under the Kassabaum-Kennedy Act, the industry will have to comply. Those responsible for the security of electronically maintained medical data should keep abreast of changes and improvements in the industry and implement the most up-to-date mechanisms to assure security and data privacy.

CONCLUSION

Electronic communication privacy protection and security measures are rapidly evolving areas of the law and public policy. However, technology has always outpaced law and policy, and electronic communication is probably no exception. Therefore, the new federal standards need to be somewhat flexible, enabling the industry to meet the requirements of the law without unnecessarily restraining progress. Also, the standards should be clear so that compliance is easily understood. The criminal penalties arising from the new federal law are alarming, but apparently lawmakers believe the penalties are warranted to ensure that measures are in place to protect computerized health information. MM

Mary Prentnieks recently graduated from the Harvard School of Public Health. Shirley Qual, a shareholder with the new Minneapolis law firm of Halleland, Lewis, Nilan, Sipkins and Johnson, P.A., is a nurse attorney practicing in the area of health care law.

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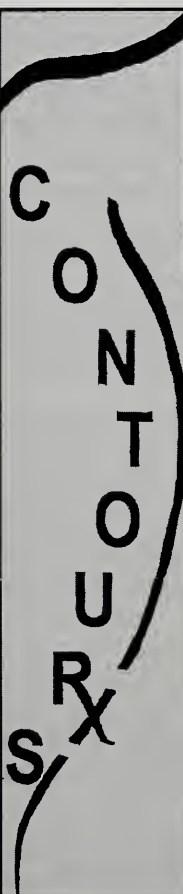
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MMA Releases Comprehensive Telemedicine Report

"The Minnesota Medical Association's Report on Telemedicine" explores emerging issues related to the electronic delivery of medical care, focusing on medical licensing, liability, and patient protection.

Patricia L. Franklin, J.D., and Patricia C. Hanson, R.N.

Telemedicine is emerging as an issue of importance to physicians as more and more health care is delivered via electronic means, particularly in rural areas. Telecommunications, digital technologies, and telemedicine are being developed and deployed at an ever-increasing pace, and regulatory agencies are attempting to catch up and respond to the changes. In this formative stage, physicians have an opportunity to impact the future of telemedicine and the standards that govern its use.

Telemedicine may be the single most important and dramatic change in health care this century, and physicians need to become familiar with its use. Although skeptics may deny that telemedicine will succeed, the prevailing view of experts is that telemedicine will prosper and radically change medical care. According to Michael E. DeBakey, M.D., a renowned cardiac surgeon at Baylor College of Medicine, "Having now come of age, telemedicine has the potential of having a greater impact on the future of medicine than any other modality."

The Minnesota Medical Association's 1995 House of Delegates recognized telemedicine's importance and commissioned a report to address the myriad issues raised by the expansion of telemedicine. Along with providing a working definition of telemedicine to facilitate discussion, the report examines the advantages of delivering care via electronic means and details the obstacles to a more rapid expansion of telemedicine.

Several experts cite the following advantages:

- improved health care access;
- improved continuity of care and access to medical record information;
- a potential decrease in health care costs;
- enhanced patient education;
- improved timely diagnoses and treatment; and
- improved medical education, continuing medical education, and professional collegiality, particularly for rural physicians.

Impediments to a more rapid expansion of telemedicine include:

- the controversy surrounding state medical licensure issues;
- a lack of telemedicine standards for professional credentialing and care provision;
- complications that could occur in the medical malpractice system;
- a lack of reimbursement for care provided telemedically;
- potential technical problems;
- professional protectionism and increased competition among providers;
- a lack of an intrastate and interstate infrastructure to support telemedicine;
- potential for seeing a decrease in the "art" of care provision;
- a lack of patient and provider acceptance of new technologies;
- a possible decline in confidentiality of patients' medical information as access to medical records increases;
- the complexity of the technology; and
- the question of where medical practice occurs when care is provided telemedically.

The report provides a review of current state licensing laws and analyzes whether providers need to be licensed in every state where they might practice telemedically. The report also looks at questions pertaining to liability and patient protection. Several organizations have already offered a number of possible solutions, including the American Medical Association and the Federation of State Medical Boards. In addition, several states have attempted to address this issue through legislative initiatives.

The report summarizes the technical aspects of the telecommunications infrastructure necessary to support telemedicine capabilities. Current national and state research and demonstration projects are also described.

The report concludes with 12 policy recommendations that the MMA Board of Trustees adopted at the 1996 MMA Annual Meeting in September, the most controversial being a recommendation dealing with licensure (see recommendation number nine in the complete telemedicine report).

To order a copy of the 28-page report, call Pat Biersach at 612/378-1875 or 800/999-1875. MMA members are eligible for one free copy. Members can purchase additional copies at the following rates: two to 10 copies, \$15 each; 11 to 25 copies, \$12.50 each; and 25 or more copies, \$10 each. Nonmembers can purchase a copy of the report for \$25. Postage and handling are additional for nonmembers.

MM

Patricia Franklin is director of legal affairs and Patricia Hanson is manager of quality and data at the Minnesota Medical Association.

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People and Places Making Medical News

People

ACCME Appointment

The Accreditation Council for Continuing Medical Education (ACCME) has appointed Robert C. Moravec, M.D., to its Committee for Review and Recognition (CRR) for a three-year term beginning January 1, 1997. The ACCME accredits organizations to sponsor CME for physicians; the CRR recognizes state medical societies as intrastate accreditors of CME sponsors.

Moravec, medical director of HealthEast Medical Education in St. Paul, has served as a member of the Minnesota Medical Association's Committee on Accreditation and Continuing Medical Education for the past six years, including three years as committee chair.

HealthSystem Minnesota New Senior Vice President

William S. Shimp, M.D., has been named senior vice president, hospital and consultative services, for HealthSystem Minnesota. In this newly created position, Shimp will be responsible for the hospital and specialty services of HealthSystem Minnesota and will serve as principal liaison between its management team and Methodist Hospital HealthSystem Minnesota medical staff.

Places

'U' Bone Marrow Transplant Program Named NHLBI Transplant Center

The University of Minnesota Bone Marrow Transplant (BMT) Program has been designated a National Heart, Lung and Blood Institute (NHLBI) transplant center. The announcement coincides with a multimillion dollar national effort to expand the applications of umbilical cord

blood transplantation, a promising treatment for deadly blood diseases.

The NHLBI designation includes a \$727,000 contract, which the BMT Program will use, along with part of its \$5 million National Institutes of Health grant, to study alternative sources of stem cells.

To date, 25 cord blood transplants have been performed at the University of Minnesota, placing it among the top two institutions in the world that are advancing this therapy. Under the new NHLBI program, approximately 90 transplants will take place over four years.

HealthEast to Build St. Paul Clinic

HealthEast has begun constructing a new facility for a clinic affiliated with the family practice residency program operated by the University of Minnesota Department of Family Practice and Community Health (DFPCH). Located at 568 Rice Street, the new University Family Practice-Bethesda Clinic will be one of five residency clinics in the Twin Cities that DFPCH administers. HealthEast owns the land and, with the St. Paul Department of Economic Development, is helping to finance the project.

The existing facility, at 590 Park Street, is staffed by 26 University of Minnesota family practice residents under the supervision of five DFPCH physicians.

HealthEast Orthopaedic Implant Registry Wins Innovation Award

St. Paul-based HealthEast won the 1996 Spirit of Innovation Award for developing the nation's first community-based computerized registry to track orthopaedic implants. The registry pools information from all HealthEast's

orthopaedic surgeon groups performing total joint replacements. The award was cosponsored by InterHealth and 3M Health Care.

Before it initiated the registry, HealthEast had no systemwide data to compare costs of implant devices or implant longevity of hip and knee replacement. "Since the registry began in 1993, HealthEast has decreased implant costs \$3.6 million as a result of surgeon collaboration on implant use guidelines and standardization on cost-effective, quality implant devices for hip and knee replacement," said Kathleen Killeen, senior director of HealthEast's Orthopaedic and Neuroscience Services.

St. Mary's Clinic for Medically Underserved Opens in Shakopee

Because of significant population growth in Scott County, Carondelet LifeCare Ministries has established a St. Mary's Health Clinic located at First Presbyterian Church in Shakopee. The clinic is free, nondenominational, and open to all who may be eligible to receive medical treatment. St. Mary's clinics were started in 1992 to care for people in the Twin Cities metro area who cannot afford medical treatment, are without health insurance, and are ineligible for government subsidy programs.

National Institute on Media and the Family Created

David Walsh, Ph.D., a psychologist with Fairview Health System and an expert on media and the mind, announced the formation of a new national resource for research, information, and education about the impact of the media on children and families. The National Institute on Media and the Family, based in Minneapolis, will evaluate media products and summarize its

findings in forms it's calling Children's Impact StatementsSM.

Each statement will provide a brief synopsis of new movies, television programs, ads, video games, Internet sites, and other media, and will evaluate the products with regard to age appropriateness, violence, language, sexual content, and how they portray core values and character traits. The impact statements will be available to the public through a subscription newsletter to members of the institute, releases to the media, a telephone dial-in service (1-888-672-KIDS), and a World Wide Web site (mediaandthefamily.org).

Walsh is executive director of the institute, which is based at Fairview Riverside Medical Center. Fairview is a founding sponsor.

Sister Kenny Institute Shifts to Reality-based Therapy

Abbott Northwestern's Sister Kenny Institute, the Twin Cities' largest acute rehabilitation center, has completed a \$750,000 physical renovation intended to better prepare patients to reenter the community as quickly as possible. Known as Independence Square, the simulated village includes a bus and car, shops, and different walking surfaces so patients can practice real-life activities.

"This is consistent with the movement in medicine to become more patient-focused and practical, working on outcomes that directly and most immediately affect patients' lives," said Jennine Speier, M.D., physical and rehabilitation medicine specialist and medical director of Sister Kenny Institute.

Socioeconomics

Fairview Announces Job Cuts

Fairview Riverside Medical Center may have to eliminate up to 400 full-time equivalent positions as a result of HealthPartners' recent decision to move its business from

that hospital to Methodist Hospital. Administrators at Fairview are preparing for the loss of its major HMO customer by the end of the year.

Jean Tracy, media relations manager for the medical center, said, "We're optimistic that, through attrition and placement elsewhere in the Fairview system, the number won't be that high."

Fairview Riverside employs about 3,400 people, about 3,000 of whom have full-time equivalent positions.

Abbott and St. Francis Join Preferred One Network

A new agreement has been reached between Allina Health System and Preferred One that will allow Allina's Abbott Northwestern Hospital in Minneapolis and St. Francis Regional Medical Center in Shakopee, co-owned by Allina and the Benedictine Health System, to join Preferred One, a preferred provider network.

A number of Allina facilities, including United Hospital in St. Paul, have been long-time members of the Preferred One network.

"This new agreement will provide the communities we serve better access to our health care services," said Gordon Sprenger, executive officer of Allina Health System.

Patients covered by Preferred One have used Abbott Northwestern in the past but have had to pay higher out-of-pocket costs for going outside the network. A number of employers in Shakopee offer Preferred One to their employees. The new agreement will allow those employees to be referred to the St. Francis Regional Medical Center, which recently relocated to a new building on the South Valley Health Campus in Shakopee.

Florida Firm Will Acquire Health Risk Management

HealthPlan Services Corp. of Tampa, Florida, plans to acquire

Health Risk Management, Inc., of Edina, Minnesota, for about \$80 million in cash and stock. The deal is expected to be completed in early 1997. Gary McIlroy, M.D., HRMI's chair and chief executive officer, said the acquisition will allow the company to expand locally. HRMI has about 800 employees in Minnesota and four other locations.

HRMI is a managed care services company that has developed clinical decision support software to enable payers and providers to manage their health care risk.

Human Sexuality Program Receives HIV Prevention Study Grant

The Program in Human Sexuality at the University of Minnesota Medical School has received \$1 million from the Centers for Disease Control and Prevention (CDC) to study the effects of HIV prevention programs targeted at women of color and men who have sex with men.

The three-year study will investigate the effects of two HIV education programs—"Man-to-Man: Sexual Health Seminars" and "Women's Initiative for Sexual Health (WISH)"—both designed by university faculty in conjunction with the Minnesota Department of Health, the Minneapolis Urban League, African American Family Services, and Turning Point.

ENT Clinic Merges with Head and Neck Clinic

Minneapolis Ear, Nose & Throat Clinic, P.A., and Head and Neck Physicians and Surgeons Clinic, P.A., of St. Paul merged as of October 1. The new entity—the Ear, Nose & Throat SpecialtyCare of Minnesota, P.A.—will be staffed by 14 physicians specializing in otolaryngology and head and neck surgery and nine audiologists specializing in audiology and hearing rehabilitation.

Minnesota clinics are located in Minneapolis, St. Paul, Apple Valley, Coon Rapids, Edina, Mora,

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Roseville, Wayzata, and White Bear Lake. The group also has clinics in Hudson, New Richmond, and River Falls, Wisconsin.

Rates, Trends, Data

Rise in Scope and Severity of Child Abuse

Reported abuse and neglect of the nation's children nearly doubled between 1986 and 1993, according to a U.S. Department of Health and Human Services (HHS) study. The increase is so dramatic, the study reported, that it reflects a "true rise" in the severity of the problem rather than one based solely on heightened awareness.

The study said the estimated number of children abused and neglected rose to 2.81 million in 1993—up 98 percent from 1.42 million in 1986 when the last report was published. Child welfare workers indicate the trend is continuing.

When Donna Shalala, HHS secretary, released the report at the National Conference on Child Abuse and Neglect, she also announced \$23 million in state grants. The money will provide additional resources to community organizations for teaching parenting skills and providing other services aimed at preventing abuse.

Innovations

Researchers Develop Animal Model for Alzheimer Disease

A team led by University of Minnesota neurologist Karen Hsiao, M.D., Ph.D., has genetically engineered the first animals that model both the behavioral and neuropathological symptoms of Alzheimer disease. Hsiao said the mice will be used to study the relationship between these symptoms as a means to discover the basic problem in Alzheimer disease, as well as to test new drug therapies. The work was published in the October 4 issue of *Science*.

The genetically engineered mice appeared normal at two to three months of age. By 10 months, they exhibited impaired ability in spatial learning tasks, and their brains contained dense deposits of amyloid plaques. The presence of these plaques is routinely used to diagnose Alzheimer disease because large numbers of these microscopic deposits are found almost exclusively in patients with Alzheimer-type dementia.

"This is the first time anyone has shown an association between plaques and dysfunctional learning and memory in mice," said Hsiao. "We believe the mice offer an excellent opportunity to study the relationship between changes in the brain and behavioral abnormalities. We hope this will help settle a debate among Alzheimer disease researchers over whether amyloid plaques cause the dementia of Alzheimer disease or not."

Hsiao produced the mice in collaboration with scientists at Mayo Clinic Jacksonville in Jacksonville, Florida; the University of Wales, Cardiff; and the Veterans Affairs Medical Center in Sepulveda, California.

Upper Midwest's First TMR Heart Procedure Performed

United Hospital in St. Paul and Abbott Northwestern in Minneapolis are the first hospitals in the Upper Midwest to perform transmyocardial revascularization (TMR), a surgical procedure using a laser to help patients suffering from debilitating heart disease.

TMR creates new paths for blood flow to the heart that don't rely on the coronary arteries. For patients suffering from angina, TMR is an alternative if they are no longer responding to medical management or have unsuccessfully undergone angioplasty or bypass surgery.

The results of early TMR procedures are promising. They indicate TMR may provide angina relief, decrease hospital admissions,

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Currently, the FDA has approved a Phase I study of the TMR

laser procedure involving 12 patients across the country. United Hospital and Abbott Northwestern are among the five clinical sites where the feasibility studies are

taking place. Since 1992, about 200 TMR procedures have been done at eight U.S. hospitals.

Medical Research

Complications in Endoscopic Biliary Sphincterotomy Identified

Martin L. Freeman, M.D., a gastroenterologist at Hennepin County Medical Center, has identified complications related to endoscopic biliary sphincterotomy. His findings are reported in the September 26 *New England Journal of Medicine*.

Freeman conducted a study of patients at 17 centers in the United States and Canada undergoing endoscopic biliary sphincterotomy, a nonsurgical procedure commonly used to remove bile duct stones and treat other problems. Of 2,347 patients, 9.8 percent had a complication such as inflammation of the pancreas or bleeding.

The study found that complication rates depended primarily on the reason the procedure was done and the technique of the physician performing the procedure. Although the procedure was relatively safe when performed to remove bile duct stones, the highest rate of complications occurred when the procedure was done in an attempt to relieve recurrent abdominal pain thought to be caused by a malfunction of the sphincter of Oddi, a muscle that encircles the bile duct. A major factor in determining complications was the technical skill of the endoscopist and the volume of procedures the endoscopist had performed.

These findings suggest that outcomes are significantly better when the procedure is performed by highly trained endoscopists who have performed a large number of procedures.

Fosamax Can Harm Esophagus

The osteoporosis drug Fosamax can harm a woman's esophagus if not taken as directed, doctors at

the Mayo Clinic reported in the October 3 *New England Journal of Medicine*.

Mayo doctors became alarmed this year when they saw three postmenopausal women on Fosamax with severely inflamed esophagi, making it almost impossible for them to swallow food. The doctors contacted Merck & Co., Inc., the manufacturer of the drug. Merck said that it had received reports of 199 adverse reactions involving the esophagus, 51 of which were severe.

Mayo gastroenterologist Piet De Groen, M.D., said there appears to be nothing inherently threatening with the highly acidic drug if it is taken properly and doesn't leak back into the esophagus from the stomach. He said that about 0.5 percent of the active ingredient, alondronic acid, leaves the stomach within 30 minutes and goes to the bones, where it helps calcium bind to the bones. The rest remains in the stomach and, if the woman eats after 30 minutes, is absorbed by the food.

De Groen said it is important for women to take the drug first thing in the morning with six to eight ounces of plain water and to remain upright for 30 minutes after taking the pill and until they eat.

Doctors Study Garage-Door Injuries

Homeowners should test electric garage-door openers for resistance by using a roll of paper towels instead of a block of wood, according to an article in *Pediatrics* by a team of Twin Cities researchers. The team reported that the resistance of a child's neck and chest more closely resembles soft towels than wood.

"Standards for automatic garage-door openers before 1993 probably were not adequate to prevent injury and death to children," the article said.

Robert Kriel, M.D., Mark Gormley Jr., M.D., and Linda Krach, M.D., all of whom practice at Hennepin County Medical

Center in Minneapolis and Gillette Children's Specialty Healthcare in St. Paul, were part of the team that conducted a national survey of more than 85 children severely

injured between 1974 and 1995 when trapped under garage doors. About 87 percent in the survey died; the others had permanent brain damage. MM

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KLEEBERG *continued from page 9*

says. "The message I got was, 'If you think it's so easy, why don't you do it?' So, in November 1990, I started Fam-Med, which now has more than 1,000 subscribers throughout the world, most of them physicians." Member countries include Australia, Belgium, Brazil, Canada, Denmark, England, France, Malaysia, Mexico, Norway, South Africa, Spain, Sweden, Taiwan, and the United States.

A year earlier, Kleeberg had discovered the power, and the potential, of the Internet. "My Macintosh let out a zap, followed by a puff of smoke, and died," he says. "I was told I needed a new motherboard and given other solutions—all costing hundreds of dollars. So I got out an old laptop computer and sent an E-mail message to a Macintosh discussion group, which is like sending patient information to a medical group. Within a few hours, I had several replies. All cited the same problem and solution, gave me an 800 number to call to order the part overnight, and told me how to replace it." In less than 48 hours, his computer was working perfectly again, and it cost a mere \$60.

Changes on the Horizon

After completing his residency through the University of Minnesota in 1993, Kleeberg joined eight other physicians practicing family medicine at the St. Peter Clinic in St. Peter, Minnesota, where he currently practices two days a week. Patients come from St. Peter, nearby Le Center, and Gustavus Adolphus College. The clinic's physicians also cover the emergency room at St. Peter Community Hospital.

"What I enjoy about the practice in St. Peter is that I get to know the people and their families," Kleeberg says. "I see them in the grocery store, go to church with them, and meet them at the fair. I can reach them in

a way I couldn't in a big city, so I have greater depth with the patient in the room. When I was working with troubled kids, their problems were thoroughly entrenched by the time they made it to me. In family practice, I can see those problems early on and make a bigger difference."

In addition to practicing at the St. Peter Clinic, which Allina recently acquired, Kleeberg drives to Minneapolis three days a week and dons his technology hat. He continues to work on Allina's Internet presence and serves as lead physician for the company's roll-out of a computerized medical record in the Allina Medical Group clinics.

Kleeberg also is preparing for another change in his life. A divorced father of a 6-year-old daughter, he plans to remarry early next year and relocate to Andover, Minnesota. "I'm an only child, but my fiancée has 65 immediate relatives—all living in Andover. It's going to be quite a change," he adds.

On a more serious note, he says, "I hope to have more time for my family and my health. My family has a history of heart disease, and I don't want to be remembered for what I've done just yet. I want to have the time to get back to some of my hobbies: hiking, biking, camping, and tinkering around the house."

In the meantime, Kleeberg continues to split his time between the clinic, Allina, and Fam-Med. While his work schedule is changing, his enthusiasm for computer technology and his devotion to the family practitioner remain constant. "This is exactly what I want to be doing," he smiles, "helping improve physicians' access to information so we can provide better care." MM

Vicki Stavig is a free-lance writer living in Bloomington, Minnesota.

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

NOVEMBER 1996

Nov. 8 **E.T. Bell Pathology Symposium** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 9 **Milestones in Therapy for Congestive Heart Failure: What Have We Learned? (AHA Satellite)** University of Minnesota—Continuing Medical Education; New Orleans, LA. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 9 **Minnesota Society of Pathologists Annual Fall Anatomic Pathology Conference With Steve Silverberg, M.D.** Minnesota Society of Pathologists; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Carol Eshelman Minnesota Society of Pathologists, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875.

Nov. 9 **Minnesota Psychiatric Society Fall Scientific Conference** Minnesota Psychiatric Society; Doubletree Grand Hotel, Mall of America, Bloomington, MN. CONTACT:

Carol Eshelman, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/623-2835.

Nov. 11-13 **Clinical Reviews 1996** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 13 **GI Update** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 14 **ICare** University of Minnesota—Continuing Medical Education; Radisson Hotel Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 14-16 **Mayo Clinic Ob/Gyn Clinical Reviews** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 21-23 **Home Care Medical Directors Training Seminar** University of Minnesota—Continuing Medical Education; Embassy Suites, Orlando, FL. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 22-23 **Gas Exchange and Pulmonary Function** University of Minnesota—Continuing Medical Education; Wyndham Anatole Hotel, Dallas, TX. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 22-23 **Tenth Primary Care Update** Institute for Research and Education HealthSystem Minnesota; Radisson Plymouth Conference Center, Plymouth, MN. CONTACT: Kari Haeger, 3800 Park Nicollet Boulevard, St. Louis Park, MN 55416; 612/993-3527.

Nov. 23 **Minnesota Society of Neurological Sciences Annual Meeting** Minnesota Society of Neurological Sciences; Radisson Plaza Hotel, Minneapolis, MN. CONTACT: Lisa Deminsky, 22732 132nd Avenue North, Rogers, MN 55374; 612/588-0661.

DECEMBER 1996

Dec. 6 **Fifth Annual Family Practice Update** Hennepin County Medical Center Department of Family Medicine; Doubletree Grand Hotel, Bloomington, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

Videotapes: **Emerging Infectious Diseases** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

JANUARY 1997

Jan. 20-24 **Challenges in Hematology and Hematopathology** Mayo Medical Laboratories; Silvertree Hotel, Snowmass, CO. CONTACT: Kathy Bates, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

FEBRUARY 1997

Feb. 6-8 **Twenty-second Annual Winter CME** Minnesota Academy of Physician Assistants and Wisconsin Academy of Physician Assistants; Holiday Inn, Duluth, MN. CONTACT: Cindy Ulshafer, 1825 Center Street, Centerville, MN 55038-9779; 612/653-4736.

Feb. 10-17 **HealthEast 1997 Winter Medical Seminar** HealthEast St. Joseph's Hospital; The Melia Playa Conchal Beach and Golf Resort, Costa Rica. CONTACT: Annette Anderson, 1700 University Avenue West, St. Paul, MN 55104; 612/232-5104.

Feb. 15-19 **Selected Topics in Internal Medicine** Mayo Foundation; Rancho Bernardo Inn and Resort, San Diego, CA. CONTACT: Registrars, Mayo Foundation, Section of

Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MARCH 1997

Mar. 8-15 **Ramsey Medical Society Winter CME Conference** Ramsey Medical Society; Sheraton Resort, Xtapa, Mexico. CONTACT: Jennifer Stendahl, Ramsey Medical Society, PO Box 131690, St. Paul, MN 55113; 612/362-3701.

Mar. 14-15 **Current Issues in Cancer Prevention, Detection, and Treatment** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MAY 1997

May 6-9 **Fourth International Surgical Pathology Symposium** Mayo Medical Laboratories; Hotel Estoril Sol, Cascais, Portugal. CONTACT: Kathy Bates, Mayo Medical Laboratories, Office of Continuing Education, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Physician Cancer Support Group

A year ago, a peer support group for physicians with cancer was formed by the Hennepin Medical Society at the Virginia Piper Cancer Institute. Regular monthly meetings started in August to provide a setting in which physicians could exchange concern and feelings on the challenges unique to those in their profession with cancer. About 25 physicians and spouses have attended one or more session.

There is no charge for the group.

The group meets:

Second Thursday of each month
7 pm to 8 pm

Virginia Piper Cancer Institute
800 East 28th Street at Chicago Avenue
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If you have any questions about the group, contact Dick Sellers, facilitator, at 612/863-4000.

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Physician Opportunities and Miscellaneous Listings

Classified rates are \$2.00 a word. Minimum monthly charge is \$50; with box number \$5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., November 15 for January ad. Please send ad requests to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

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Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Olmsted Medical Center is seeking BC/BE physicians in the following specialties: emergency medicine and family medicine. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. Positions currently open include emergency room and family medicine departments in Rochester and branch office locations. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes nine branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (5/96-R)

Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: dermatology, family practice, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (8/96-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

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Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Minnesota, Iowa, North Dakota, Wisconsin: Family practice, internal medicine, ob/gyn, orthopedic surgery, geriatrics, dermatology. Contact Jerry Hess, Physician Services, 3600 West 80th Street, Suite 550, Minneapolis, MN 55431; 612/896-3492. Fax: 612/896-3425. *3-12/96

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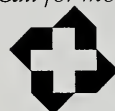
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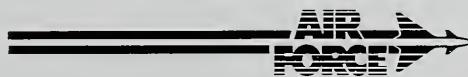
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*The Healing Power
of Spirituality*

DECEMBER 1996

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On Science and the Soul

For some, spirituality might evoke images of Halloween or levitating tables. But a truer picture emerges from a recent societywide search for the intangible core of



life. Searchers buy out Thomas Moore's books on the soul, flock to evangelical megachurches, or join one of the pantheon of groups seeking a connection to some higher being. Medicine has not been left out. Sensing "something missing" in traditional medical care, patients and physicians are looking for "something more."

This month's *Minnesota Medicine* considers whether spirituality is that something more.

Our spirituality package includes an overview on the healing power of spirituality (page 12), a personal perspective from a patient diagnosed with breast cancer (page 10), a profile of a physician working within the University of Minnesota's new Center for Spiritual Care and Healing (page 8), and a review of two books (page 29). It's a package as diverse as Neiman Marcus and one in which you can see the outlines and shadows of the spirituality movement.

What is spirituality as it relates to medicine? Here are some possible explanations:

- Spirituality acknowledges the fundamental connection between the psyche and the physical. Physicians observe that emotions produce and modify illness, health, and death.

- Spirituality recognizes the need for patients to believe and trust their healers and healing methods. In traditional medical practice, this trust rested primarily on respect for physicians, their education, and their science, whereas the current movement emphasizes the diversity of what triggers and bolsters belief and confidence.

- Spirituality's link to alternative therapies derives partly from the allure of the natural, organic, or tradition-proven

and partly from dissatisfaction with scientific medicine.

- Spirituality in medicine echoes society's groping for something higher or deeper in daily life, the search for a connection to something beyond ourselves. Patients want physicians to treat their souls, not just their stomachs. Competent soul doctors also need to know something about their own souls.

- Spirituality is not a foreign import but a native part of traditional medicine. Deepak Chopra's Westernized Hindu mysticism does sound alien, and cynics may believe the popularity of Eastern-based healing is simply baby boomers revisiting their 1960s infatuation with Eastern thought. However, church-sponsored hospitals, medical missions, and hospital chaplains attest to medicine's historical tie to religion.

- Spirituality is not asking problem-solving physician-scientists to abandon problem solving but just to consider the nonphysical in their solutions.

- Although healers in other cultures are 90 percent priest and 10 percent physician, spirituality in medicine does not mean doctors need to don shamanic robes, enter trances, and cast out demons. It does ask us to look for what's important to our patients, to hear their stories, and give meaning to their illnesses.


Strip away the Chinese herbs and meditation and the core of spirituality is connecting, communicating, and confessing. Connecting with who patients are. Communicating well enough to hear their needs. And confessing we don't have all the answers.

Growing up, I often considered following the path of my Baptist minister grandfather. I realize now that, as a physician, my role as listener, teacher, and comforter is similar. We may not feel comfortable praying with our patients, but we can minister to their needs.

Spirituality does add "something more" to medicine—something new and something old. Something new is acknowledging the diversity of our patients' physical and emotional needs. Something old is the listening, loving ear of a trusted physician.

.....
—Charles Meyer, M.D., Editor-in-Chief

.....
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Hats Off to Dr. Struve's Ideas for Approaching Unwanted Pregnancy

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Although Dr. Struve does not state his position on abortion, it is clear that he feels the majority of abortions are performed for unindicated reasons. What patients view as indications for abortions would not be indications to perform any other elective procedure. His ideas to approach an unwanted pregnancy as a crisis and to encourage the mother to see beyond the temporary hardships of the pregnancy are indeed appropriate and noteworthy. Although these methods require physicians to take quite a bit of time out of their busy practices, the results are certainly rewarding. Adequately trained paraprofessional support personnel in the community would make the physician's job easier. I think that even physicians of the pro-choice persuasion would have difficulty arguing against Dr. Struve's points.

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Physicians Should Relinquish Reproductive Control to Patients

My sympathy for the patient described in "The Consultation" by James K. Struve, M.D., compels me to respond on her behalf. I would like to ask Dr. Struve the following questions: As her family physician, did you previously prescribe contraception or obtain a sexual history for this patient? Can you explain the reason for the contraceptive failure?

Dr. Struve, although you conceded the presence of several difficulties in the woman's life, namely, job concerns, financial worries, being the single parent of one child, and a chronic medical condition that requires medication (nature of the condition is unknown to the reader), you refused to grant her what she sought—an abortion referral. The basis for this decision was the absence of indications to justify an abortion. You did not approve of abortions being done for "expediency."

The World Health Organization's definition of women's health includes not only the physical aspects, but the social, emotional, psychological, and environmental aspects of her life as well. Any one of these factors may serve as indication for interruption of a problem pregnancy.

Dr. Struve, is it not true that the patient requested an abortion referral and you refused? Did you not insist on changing her decision, one for which there were both medical and social indications?

While the duration of this second pregnancy is not mentioned, I wonder whether the patient was examined or given a pelvic ultrasound? Was a menstrual history pursued? Was her first

pregnancy a normal one, and when did it occur?

Following telephone consultations with a geneticist and a perinatologist, you assured the patient that neither her chronic disease nor her medication would jeopardize a healthy pregnancy. However, did you also explain the relative risks of an abortion as compared with childbirth, depending on the stage of gestation? Did she know that early abortion is 25 times safer than childbirth—that one week's delay of the abortion can result in a 50 percent increase in mortality and 35 percent increase in morbidity?^{1,2}

Dr. Struve, are you aware that in their zeal to reduce abortions and to promote childbirth, pro-life counseling groups often delay making a firm diagnosis of pregnancy until the pregnancy is too advanced for an abortion? Also, are you aware of the medical misinformation frequently given to patients at these clinics, e.g., abortion causes breast cancer, infertility, or serious psychological effects, and is a far greater health risk than childbirth?

As an experienced abortion provider myself, I disagree with Dr. Struve's opinion that "most physicians view abortion as destructive work, not to be done for expediency; they consider it a procedure someone must do safely to preserve personal choice and to prevent back-alley disasters." I believe that most abortion providers would describe an abortion done solely for social indications as a frequently sad experience, often representative of a failed relationship. A termination of pregnancy is also a medical procedure that usually provides tremendous, immediate relief to the patient. If the decision to terminate a preg-

nancy is the patient's choice and is in her best interest, it is the ultimate humane medical service, a true act of love. This is in marked contrast to the immorality of compulsory pregnancy, when a woman is forced to go to term, often as a result of ignorance, misunderstanding, delay, or lack of funds—or, worst of all, because a medical professional delayed referral.

Most physicians agree on the importance of available contraception for women of all ages. Family practitioners are expected to inquire about the use of contraceptives and to provide protection against unwanted pregnancy for their female patients whenever possible, especially before such a pregnancy might occur.

The expression "abortion on demand" used in Dr. Struve's article is inflammatory language that bears no truth in reality. No physician is forced to perform an abortion. If a physician declines to perform an abortion for any reason, he or she has only the ethical obligation to see that the patient receives help elsewhere.³

Surely it is the patient who can best judge her own capability as a mother. Physicians must learn to relinquish reproductive control to their patients. Although 23 years have passed since *Roe v. Wade*, many paternalistic physicians have difficulty accepting the law.

Dr. Struve was obviously disturbed by his inability to "protect" his patient from having the abortion she desired, and he deplored what he perceived as an absence of pro-pregnancy counseling, even in our pronatalist society. He was puzzled by the patient's failure to return a week later as he

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Recriminalizing abortion will not eliminate the necessity for abortion. It will only recreate the gruesome and appalling conditions that existed before the 1973 Supreme Court decision.

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Healing Body and Spirit

*As medical director of the University of Minnesota's
Center for Spiritual Care and Healing, Gregory Plotnikoff,
M.D., advocates care for the body and the soul.*

By Deborah Sugerman



Gregory Plotnikoff, M.D., thrives on keeping busy. Between teaching, research, patient care, and committee responsibilities, he steals a rare moment to talk of what is perhaps closest to his heart: integrating spirituality with medicine.

"The role of spirituality is an integral part of most non-Western healing traditions," explains Plotnikoff, who is medical director of the University of Minnesota's new Center for Spiritual Care and Healing. "We're still back in the 17th century, living in a mind-body dualism. We've made great technological advances, but we haven't done so well in treating chronic illnesses. That's why people are turning to alternative therapies," says Plotnikoff, also assistant professor of internal medicine and pediatrics at the university and staff physician at Community-University Health Care Center.

Plotnikoff feels the time for integrating spirituality with medicine is now. Evidence on all fronts supports his convictions. More people are writing about spirituality, and more people are recognizing its role in their lives and health. This past summer, a Time/CNN poll reported that 82 percent of Americans believe in the healing power of prayer, and 64 percent think doctors should pray with those patients who request it. Such momentum only fuels Plotnikoff's commitment to bring his message to America's next generation of doctors.

"We need to change the paradigm, to transform the educational process," he says. "We need to go back and remember the core values of care and service that form the basis of health care."



PHOTOGRAPH BY BRUCE BAIRD

diverse cultures and belief systems. "Spirituality is about people looking for purpose, meaning, and value, about connecting with a greater whole," says Kreitzer. The center did not hesitate to arrange for a medicine woman to attend to a patient and a shaman to conduct a pipe ceremony. Of course, logistics sometimes become an issue. For the pipe ceremony, staff had to make

The university's Center for Spiritual Care and Healing is Plotnikoff's laboratory for change. Begun in May 1995, the center grew out of the chaplaincy service at the University of Minnesota Hospital and Clinic. "Nurses, chaplains, and interested others came together and organized an administrative structure," explains Plotnikoff. A \$150,000 Arthur Vining Davis Foundation grant supports teaching and research.

"We hope to create a new vision for spiritual care, integrating it into the health care delivery system," says Mary Jo Kreitzer, Ph.D., R.N., the center's administrator. "Attentiveness to spiritual needs is critical to patients' healing and wholeness," adds Kreitzer, also director of nursing practice and research and administrator for quality at the University of Minnesota Hospital and Clinic.

What does this new vision for spiritual care look like? "The center has no bricks and mortar," says Plotnikoff. Rather, it provides an infrastructure that allows compassion and sensitivity to patient and family needs to be integrated with high-tech, state-of-the-art medical care.

A striking aspect of the center is its embrace of

sure the smoke detectors in the meditation room were disconnected.

Besides providing care for patients, the center educates health care professionals and Academic Health Center students through informal workshops, brown bag seminars, presentations by nationally acclaimed speakers, and interdisciplinary courses. The center also plans to conduct research on spirituality, health, and healing, and to disseminate existing research on spirituality and medicine in a newsletter.

Plotnikoff stresses that a team of doctors, nurses, chaplains, and other health care professionals carry out the work. He and Kreitzer agree that individuals from a variety of disciplines can assess and attend to the spiritual needs of patients. Of Plotnikoff's contribution to the team, Kreitzer says, "He has vision, passion, and sensitivity, as well as credibility among his peers."

Plotnikoff's vision began early in life. His drive to be a physician equalled a long-standing concern about the dehumanizing effects of technology.

PLOTNIKOFF continued on page 44

A Call for Open Mindedness

*One woman's healing journey has tested her
beliefs about how people
grow and heal.*

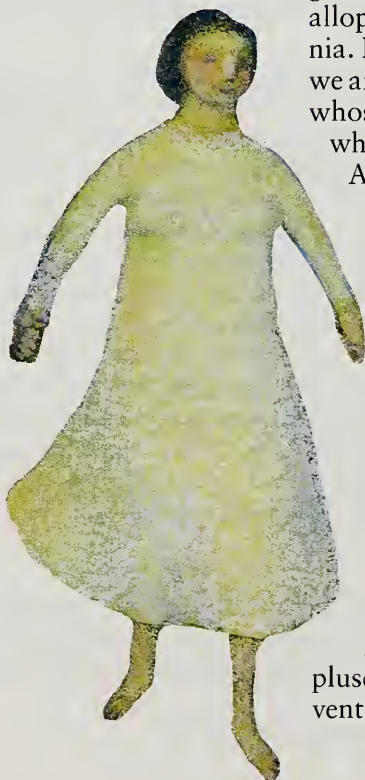
By Penny George, Psy.D., L.P.

I was diagnosed in late February with breast cancer and recently completed seven months of chemotherapy following a mastectomy. My treatment has given me a unique opportunity to test my belief that true healing cannot be separated from its spiritual foundation.

My beliefs about how people grow and heal are grounded in my past. My great-great-grandfather was a medical missionary who gave up a career in allopathic medicine to become one of the early homeopaths in Pennsylvania. Both of my grandfathers were Protestant ministers who taught me that we are primarily spiritual beings in body form. My father is a retired surgeon whose view of his work is totally allopathic, but who is also an idealist with whom I made house calls on horseback to indigent patients in the Appalachian Mountains, where I grew up. And my husband is chair of Medtronic, a corporation that has effectively used technological advances to restore people to fuller lives. Like him, I am an advocate for high-tech, state-of-the-art medicine.

I have been blessed with excellent, respectful medical care at the Virginia Piper Cancer Institute. My oncologist talks to me as an intelligent adult and is willing to discuss my explorations into complementary realms of healing. Although he does not support all complementary therapies, he does not criticize me for using them.

I am sure I would not have come through surgery and chemotherapy as uneventfully as I have—nor endured the countless shots I must give myself in the stomach to boost my white cell counts—without the additional elements of healing I have put in place. I realize the medical community doesn't know enough about the mechanisms of cancer to assure that what I'm doing will prevent a recurrence. On the other hand, I don't have anything to lose, and the pluses are a vastly improved quality of life and the possibility of preventing other problems, like heart disease and depression.





The route I have followed has been largely intuitive, but on reflection, I see that I have been addressing not only the needs of my body, but also of my mind, heart, and spirit.

As for my body, my belief in allopathic medicine made chemotherapy an easy choice, although not all people I consulted suggested that route. In addition to chemotherapy, I work to build my body's resilience and increase my awareness of its needs; for this, massage has been very helpful, both to soften scar tissue from the surgery and to release tension. I also do energy work to erase the fatigue of chemo-

material. In addition, I underwent two sessions of hypnotherapy to help me during a rough period when I was having difficulty picturing myself in the future.

As for my heart, my biggest challenge has been learning to grieve and to experience other feelings I had successfully repressed for years. I have struggled to believe that I matter. I wonder what impact such beliefs about our right to a place in this universe may have on illness and health. I work to heal my heart

therapy. I work out and eat a balanced diet. I am exploring what Chinese herbs and acupuncture have to offer in combating the severe hot flashes that are a side effect of taking the drug tamoxifen.

For my mind, I strive to fully understand the state of research in cancer treatment so that I can make informed decisions and understand my disease. I use mental strategies to neutralize my overactive internal critic. I have attended some fine local workshops and have read voluminous amounts of

HEALING JOURNEY continued on page 46

The Healing Power of Spirituality

Jackie and her family had experienced a horrible five days. After slamming into a tree on a snowmobile, Jackie's son was in serious condition in the intensive care unit at Mercy Hospital in Minneapolis. Even after the family learned he would recover fully, the issue of his drinking—the ultimate cause of the accident—weighed heavily on them.

Physicians are helping patients look beyond the physical dimension to find comfort, answers, and cures.

BY KATIE COLÓN

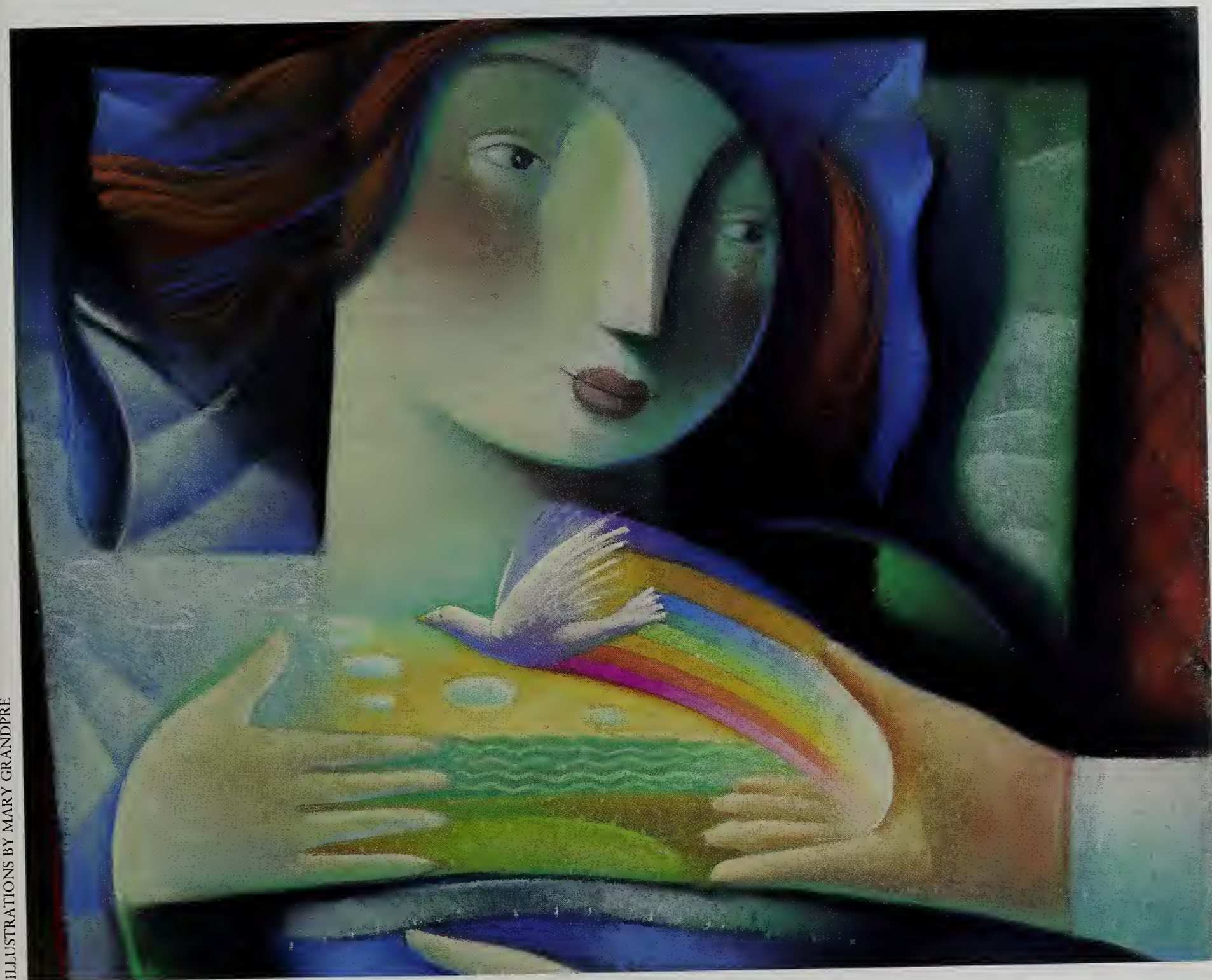
Rodney Lovett, M.D., was the on-call surgeon when Jackie's son was admitted. Lovett showed genuine concern for both Jackie's son and the family, staying past his on-call duties to keep an eye on the boy's progress. On the day before discharge, Lovett gently put his hand on Jackie's shoulder and said, "I want you to know I've been praying for your son."

It was a powerful moment for Jackie. "There was so much caring in his voice," she says. "A lot of family and friends were praying for my son. But to have the one who was caring for him say that really meant a lot."

Jackie's experience reflects a message that is gaining in momentum. The vast majority of Americans believe that spirituality influences their recovery from illness, injury, or disease, says one recent poll.¹ Nearly two-thirds of those who responded to national surveys by USA Weekend and Time/CNN indicated they would like physicians to talk with them about spirituality as it relates to their health or even to pray with them.^{1,2} An abundance of articles, books, and conferences in recent years have addressed the impact of spirituality on patient, physician, and health care. And the topic made the cover of *Time* magazine in June. Last month, a Mayo Clinic conference on spiritual care research sold out.

This message—that health care has a spiritual component—flies in the face of modern Western health care culture, which holds to a biomedical model for healing and recovery. Such a model understands treatment as that which can be prescribed for the body. The soul is not part of the therapy equation.

In his book "Manifesto for a New Medicine," James S. Gordon, M.D., founder and director of the Center for Mind-Body Medicine in Washington, D.C., writes that medical education is long on technical mastery but short on issues of personal and spiritual growth. Such training "has very real and very dangerous consequences for medical practice," he says. "Unschooled in our own thoughts, feelings, and reactions, we come to see ourselves as fundamentally different from those for whom we care ... grossly unaware of our own moods and motivations and



ILLUSTRATIONS BY MARY GRANDPRÉ

insensitive to the power of our words to heal or harm.”

Are recent trends in public attitude calling for a new era in medicine? Does spirituality play a legitimate role in the physician-patient relationship?

Exploring the Connection

To even begin to answer these questions requires some understanding of spirituality. It is often defined as the experience of meaning and purpose in our lives—a sense of connectedness with the people and things in the world around us. For many, this connectedness encompasses a relationship with God or a higher power. As Sister Mary Eliot Crowley, counselor

for human values and sponsorship at Saint Marys Hospital in Rochester notes, “Everyone has a spirituality, we just express it in different ways.”

The connection between spirituality and medicine is not new. Many modern hospitals have religious roots, and in many cultures, healing and spirituality are closely tied. Many Southeast Asian cultures, for example, share a core belief that the soul has to be well for the body to be well, explains Kathleen Culhane-Pera, M.D., family practitioner at the West Side Community Health Center in St. Paul and director of Cross-Cultural and International Family Medicine at St. Paul-Ramsey Medical Center.

Among patients often turn to spiritual healers or

shamans to help give meaning to their illness and to give them strength to deal with it, Culhane-Pera says. "As physicians, we need to recognize that spirituality is often a very important part of who a person is. We need to ask our patients about their [spirituality] and support them in what they feel they need to do for themselves."

Greg Filice, M.D., chief of infectious disease at the Veterans Affairs Medical Center in Minneapolis, recognizes the spiritual connection in his practice. "It's not just a patient's chemistry you're treating, but the whole person," he says. "The mind has a great influence over what is happening in the body, and a person's spiritual connections can help doctors to help their patients."

One of Filice's primary roles at the VA is teaching bedside patient care to students, residents, and fellows. A "compleat" physician, he says, must address spiritual, social, and psychological issues as well as medical ones. "We have a very well-defined role as

patient advocate," he explains. "It is important to understand the patient's needs, beliefs, and desires so we can present appropriate options."

Asking patients if they have a faith and whether they would like to talk to someone about it is not only appropriate, according to Filice, it's good medicine. "If faith is important to the patient, it is probably going to be an important part of treatment and care. Physicians need to understand that dimension of the patient and patient's family."

Unfortunately, incorporating the spiritual into a patient's treatment plans doesn't happen very often in a teaching hospital, says Filice. "We have four full-time chaplains at the VA, but they don't talk to the doctors about patient care, and the doctors don't talk with them."

Mary Farr, manager of pastoral care at Children's Health Care—St. Paul, offers her insights on the relationship between spirituality and health care. "Pa-

Spirituality and the Medical Oncologist

BY EDWARD CREAGAN, M.D.

Through strong social and spiritual connections, some cancer patients enhance their quality of life and defy medical prognosis.

I have long been fascinated with distance runners from Central and South America, East Africa, and some American Indian tribes of southwestern United States, who achieve incredible feats of endurance. Despite rudimentary training and little study of physiological principles, they excel.

I, too, am a distance runner. (At 5 feet 9 inches and 128 pounds, one's athletic options are limited.) During my younger days, I achieved some success, but only recently did I attempt such a demanding event as a marathon. Medical school taught me physiology, and I have trained carefully. Yet the distance runners I so admire knew something I didn't. Their intense spirituality connected them to higher powers, their ancestors, and nature, enhancing their performance.

If such a strong faith could achieve athletic feats, I wondered, could faith also influence medical prognoses? After approximately 25 years as a medical oncologist, I am convinced this is the case. I am intrigued by the small number of patients with grim prognoses who go on to live meaningful, productive,

creative lives. Statistical models and surgical staging interventions allow oncologists to accurately predict median survival among groups of patients, but when dealing with an individual patient, we are woefully inadequate in predicting how long that person might live. Of the patients who continue to do well, many lack an explanation for their success. However, I have noticed that like the distance runners, these patients have a few significant characteristics in common.

Many share a sense of connectedness with family members and participate in community activities and civic organizations. Their social network provides them security against isolation and disfranchisement. These patients also find strength and comfort in their spirituality—different from religion, which encompasses the rituals and ceremonies of a specific faith community—and the notion of a transcendent power. Finally, long-term survivors also share a sense of purpose, meaning, or a goal in their lives. For instance, the birth of a grandchild, a child's marriage, or a graduation can sustain patients dealing with advanced malignant disease.

One such patient was a middle-aged homemaker from the Midwest. Despite progressive metastatic disease, the patient was determined to attend her son's wedding in another state. The patient seemingly ral-

tients have a huge need to search for meaning in the face of illness and loss," she says. Spiritual concerns often include a sense of powerlessness, isolation, and fear. Physicians have to at least be mindful that at the heart of every single illness lies a human need for connection and intimacy, she says.

That doesn't mean physicians necessarily provide that spiritual component, says Farr. "But a few well-placed questions can give the physician information about the needs of the whole person, not just the patient's medical needs," she adds.

For example, asking open-ended questions such



as, "How do you feel about your illness?" or "How do you cope?" can leave the door open for patients to talk about their spiritual concerns or a whole belief system without the doctor ever asking a direct question about religion or spirituality. An awareness of patients' needs then allows physicians to mobilize other resources to help meet those needs.

This fall, Farr began offering a series of noon lectures on spirituality and related topics for family practice and pediatric residents at Children's Health Care. The lectures—which cover topics such as the history of spirituality and medicine and the meaning of health, illness, and loss—discuss issues medical students spend little, if any, time talking about in school, says Farr, who recently completed clinical training in mind-body medicine at Harvard Medical School.

Building a Healing Partnership

Teaching physicians that spirituality is an important component of medical care is one thing. Changing the physician-patient relationship is quite another. "Real healing comes ... when one changes from simply treating someone, to teaching as well as treating; when one changes from compliance—one of the most often used and perhaps the ugliest word in the medical vocabulary—to collaboration," said Gordon in the first annual Robert Kaplan Memorial Lecture in April at Park Nicollet Clinic in St. Louis Park.

By collaboration Gordon means listening to patients to find out what is important to them. "It means not only explaining to someone why you are prescribing what you are, [but also] finding out what's in it for the patient and what problem he or she is really wanting to treat."

Listening can also help in identifying the underlying cause of a patient's illness. Gregory Plotnikoff, M.D., M.T.S., medical director of the University of Minnesota's Center for Spiritual Care and Healing (see profile of Plotnikoff, page 8), recalls an encounter between a medical resident and a patient complaining of fatigue and weakness. Each time the patient referred to personal difficulties, such as gambling debts, alcoholism, and divorce, the resident cut in with questions like, "You're divorced?" and "Do you have children?" By not allowing the patient to tell his story, Plotnikoff explains, the resident missed a

lied for the event but quietly passed away after returning home. This type of experience is not unique among medical oncologists. Once an important event is over, or even following the death of a pet, some patients literally lose the will to live and succumb to their cancer.

Extensive population-based research, as well as studies on patients with certain neoplasms, shows that lack of social connectedness is a major risk factor for mortality. How, then, do we explain why the young patient with a supportive family and much to live for dies early from advanced disease? Long-term cancer survivors are often characterized as fighters and optimists, but what happens when the cancer progresses and treatment doesn't work? Patients who feel responsible for their health and wellness can easily conclude they aren't trying hard enough. That is a heavy burden to bear.

For this reason, we must accept emerging medical literature that shows the biology of the cancer is the single most important factor in survival. Still, we can't ignore the tremendous and dramatic impact a solid social network and spirituality have on quality of life and survival.

MM

Edward Creagan is an oncologist at the Mayo Clinic in Rochester, Minnesota.

crucial opportunity to explore what was behind the patient's clinical concerns.

"We've been trained to hand over answers," says Plotnikoff. But the answers to some questions aren't found in a medical text. Questions such as "Why me?" and "Why now?" touch on the deeper meaning of life, and their answers can only come from within the patients themselves. Appropriate questions from a physician can help patients to discover this meaning, says Plotnikoff.

Farr relates a story that illustrates how simply listening can heal. A pediatrician drove to the emergency room one Sunday morning to be with a young couple whose 4-month-old had just died of sudden infant death syndrome. "The loss of a child is traumatic," says Farr. "It's a situation that nobody, not even a chaplain, would find comfortable." The doctor sat with the family and listened. He didn't try to intellectualize their pain and gave no notion of wanting to escape. No biomedicine took place that morning, says Farr. Instead, the family experienced a different sort of healing power.

Finding a Place on the Continuum

Depending on their own understanding of spirituality, physicians may or may not be eager to embrace it as an element of patient care. The word "spirituality" itself scares some people off, says Plotnikoff. "They are usually reacting to something in their past that relates spirituality to dogma, a set of given answers that leaves no room for personal explanations of one's own truth."

When physicians react to their own discomfort with the idea of spirituality, they may lose the opportunity to connect with the patient and discover something of value, he says.

University of Minnesota hematologist Dale Hammerschmidt, M.D., points out that many physicians experience an "overwhelming aura of awkwardness" when the issue of spirituality and health care comes up. "There are so many different orientations to spirituality," he says. "In our pluralistic society, where does the physician cross the line from being supportive to being intrusive?"

While certainly not adverse to listening to patients,

Hammerschmidt believes there is a certain risk that discussing spirituality will get in the way of medical objectivity. "If you are in a situation where a patient is dealing with you as both a physician and spiritual counselor, it may be hard for the patient to distinguish which voice you are speaking with," he says. "It may color patients' decisions for treatment if they view you as a spiritual authority." Hammerschmidt is also concerned that the physician's own ability to remain objective and to offer a counseled professional opinion may be compromised as a result.

"To avoid embarrassment or being intrusive, physicians often completely secularize the relationship. I think a lot of us are guilty of that," he admits, adding that he was shocked to learn that some patients assumed he was an atheist because he had not incorporated spirituality into his patient care.

Although many physicians do not talk to patients about spirituality, polls show most Americans would like them to. The Time/CNN survey found that 64 percent of Americans believe doctors should join their patients in prayer if the patients request it, and 82 percent believe in the healing power of personal prayer.²

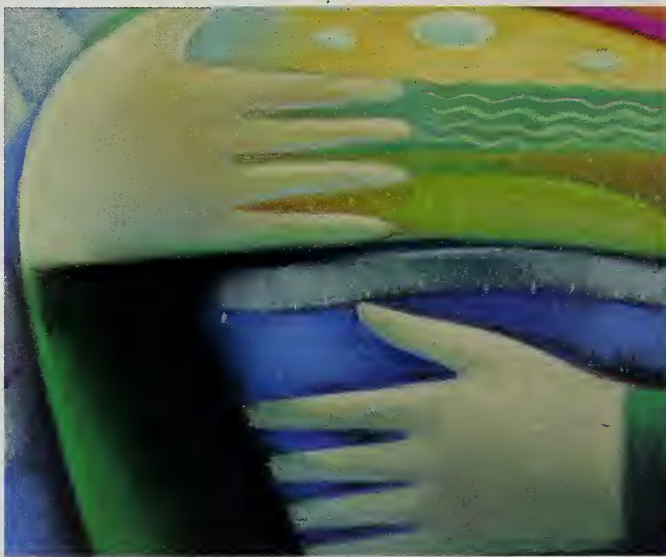
Prayer and spirituality have played a role in patient care for Chris Hook, M.D., Mayo hematologist and oncologist. "When I share faith and prayer with patients, I do not offer myself as a spiritual authority," explains

Hook. "I let the patient and family know that I, too, have my own questions and concerns. It helps humanize the whole process for all of us."

Hook recounts the story of a young man diagnosed with lymphoma. In discussing treatment options with him and his wife, Hook discovered the patient had a strong faith in God. The wife was scared. After a long, difficult afternoon, Hook asked them if they wanted to pray together. The answer was an enthusiastic yes.

"That moment was a major turning point for the couple," Hook recalls. "They walked out of our meeting with confidence and ready to face that course in their lives. When it came time to make decisions about terminating the man's life support, there was a sense of peace that we were all there together."

"I wish I could have this kind of relationship with



more patients," Hook says. "It helps to make being a healer the greatest thing on earth."

John Woods, M.D., a retired plastic and reconstructive surgeon at the Mayo Clinic, is also up-front on the subject. "I don't think patients will ever be offended if they are asked about faith or prayer with sensitivity," he says. "You always give the patient the choice."

Woods regularly performed surgery on patients who had cancer of the head and neck, including malignant melanoma. For several years, he also did kidney transplants. "I saw patients who knew there was a threat to their life," he recalls.

"At first I would deal in generalities, discussing outlooks. I might say, 'There is enough of a threat here of dying that if there are things you need to do to get your house in order, you probably want to do that now.' That often opened the door for patients to talk about their faith if they had one, and about prayer." When Woods sensed a patient's apprehension before surgery, and if it was someone he had come to know well, he often indicated he was praying for them.

"There is much concern these days about being inclusive, about being politically correct," says Woods. "But if you avoid asking about prayer because of the rare patient who might take offense, you rob other patients of the comfort and encouragement they may gain from it."

Of course, some physicians may not be comfortable with prayer because it isn't part of their own spiritual practice. Or, a physician's spiritual understanding may be quite different from a patient's, depending on their religious upbringing and cultural background. In such situations, Farr suggests physicians can offer to bring in a chaplain, rabbi, or cultural healer.

For example, to help meet the needs of patients and families from various cultures and beliefs, Children's Health Care has permitted shamans to come in for Hmong families, tribal elders for Native American patients, and has encouraged Hasidic Jewish families to partake of food and rituals important to them. "We are, of course, practicing Western medicine, and there needs to be some respect for those boundaries," says Farr. "What we try to do is safely create a space to do both spiritual and biomedical medicine with these families."

Looking Within

David Larson, M.D., president of the National Institute for Healthcare Research (NIHR) in Rockville, Maryland, says evidence is mounting that a positive link exists between a patient's spirituality and that person's recovery and ability to cope with illness. Yet he adds that research also shows that nearly 90 percent of physicians do not address their patients' spiritual needs. ➡

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Under Larson's direction, the NIHR is trying to uncover the neglected factors in health care, including spirituality. "Patients are unaware of the culture of medicine that says [the subject of spirituality] is taboo," says Larson, author of the 1995 book, "The Neglected Factor." He believes that physicians can no longer afford to ignore the relationship between clinical outcomes and a patient's spirituality.

To this end, NIHR awarded five \$10,000 grants in 1996 to medical schools across the country to help them incorporate classes on religion and medicine into their curricula.

While these classes are still taking shape, "Medicine in Search of Meaning," a program sponsored by the Catholic Health Association of Wisconsin, has given physicians an opportunity to discuss spiritual issues. Developed in 1993, the six-hour program has attracted national interest, leading to the development of a training manual that 12 major health care systems across the country use.

Closer to home, an interdisciplinary group of University of Minnesota faculty seeking a more holistic approach to patient care has formed the Center for Spiritual Care and Healing (see "Healing Body and Spirit," page 8). As part of the center's efforts,

Plotnikoff teaches a one-day workshop on spirituality and medicine for senior medical students at the university.

At Mayo Clinic, a group of physicians, nurses, therapists, social workers, and others involved in patient care meet each month to talk about spirituality, what it means to them, and how it is alive within the Mayo system. In November, Mayo Clinic sold out a conference on "Spiritual Care Research—What We Are Learning."

Increasingly, physicians are being called to look within. "The final grace of the healing partnership," said Gordon in his Kaplan lecture, "is that it is not only about helping other people ... but it also creates a situation in which we can pursue our work with the kind of passion that we all expected to have when we went into it in the first place."

MM

Katie Colón is a free-lance writer residing in Ramsey, Minnesota.

REFERENCES

1. USA Weekend Faith and Health Poll. USA Weekend 1996 April 5-7:5.
2. Kaplan M. Ambushed by spirituality. Time 1996 June 24:62.

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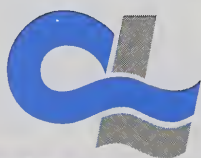
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Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. *Mayo Clinic Proc* 1986;61:859-64.
2. Guttormson NL, Bublrick MP. Mortality from ischemic colitis. *Dis Colon & Rectum*, to be published.
3. Chatterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.
4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. *Pediatric Surgery*, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

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The Care and Cost of Snowmobile-related Injuries

David R. Farley, M.D., Todd F. Orchard, M.D., Michael P. Bannon, M.D., and Scott P. Zietlow, M.D.

ABSTRACT

From January 1, 1991, through May 1, 1993, we identified 42 patients from our prospective computer-based trauma registry (38 males, four females; mean age, 25 years) who were hospitalized after snowmobile accidents. The primary reason for hospitalization varied: bone fracture (n=18), blunt abdominal trauma (n=nine), closed head injury (n=five), and miscellaneous injuries (n=10). The mean Injury Severity Score was 9.3 (range, one to 43; median, nine). Twenty-six patients (62%) required emergent operation. Mean hospital stay was six days (range, one to 16 days). Thirteen patients had complications: seven had wound infection; three, ileus; and three, miscellaneous. One severely injured hypothermic patient died. Medical charges totaled \$569,566 (mean, \$16,227; range, \$1,003 to \$51,642).

Snowmobiling causes significant accidental injury in young persons. The physical and financial costs of such injuries are high.

Minnesota, which is consistently snow-covered from late November through early April, has about 219,000 registered snowmobiles.¹ In the last several years, we have treated an increasing number of severely injured snowmobilers at the Mayo Clinic. Minnesota has similarly witnessed a rise in snowmobile-related accidents and fatalities statewide (see Figures 1 and 2).

We had two objectives for studying snowmobile-related injuries. First, we wanted to identify the special injuries and care of this unique group of trauma patients. Our second objective was to determine the cost of subsequent medical care. Although other physicians have focused on the intricacies of caring for this subset of blunt trauma patients, including frostbite, hypothermia, and problematic transport,²⁻⁹ we feel an analysis of this group of injured patients should also address economic concerns. Minnesota is a national leader in cost-containment policies and is a hotbed of health maintenance organization competition. The state poses potentially immense financial constraints on medical care of injured snowmobilers. Changes in reimbursement threaten comprehensive managed care of these multiply injured patients. In addition to these fiscal burdens, society also pays a high price for snowmobile-related injuries: able-bodied young workers are hospitalized and often require extensive rehabilitation and recovery time.

METHODS

From January 1, 1991, through May 1, 1993, we identified 42 patients from the Mayo Clinic's prospective computer-based trauma registry who were admitted as a direct result of a snowmobiling accident. We noted patient demographics, presenting

symptoms, diagnostic work-up, operative intervention, hospitalization, complications, and overall outcomes. We scrutinized accident details, location, and transport. We also obtained and tabulated complete billing and payment records.

RESULTS

Forty-two patients were admitted to our emergency department surgical service as a direct result of a snowmobile-related accident. Males (n=38) outnumbered females (n=4), and 88% of the patients were younger than 40 years (mean, 25 years; range, 7 to 63 years). Most patients were driving the snowmobile at the time of the accident (92%). Fewer than half of all injured patients wore protective helmets (n=17).

Within two hours after the accident, 40 patients received medical care. Two solitary drivers severely injured in separate accidents were discovered approximately five and eight hours after their accidents. Fourteen patients received preliminary medical attention at outside institutions (including six for laceration care and three for operative fracture stabilization) before being transferred (range, two hours to four days) to Mayo's tertiary care facility. The patients came to our clinic by ambulance (21), private automobile (18), and helicopter (three).

Sixty-two percent of the accidents and subsequent transport occurred after sunset (see Figure 3). According to the reports of snowfall and snow cover from the National Weather Service based in Rochester, Minnesota, more than 90% of the accidents happened in areas with more than three inches of snow cover, and 71% took place within 24 hours of new snowfall. Patients or law enforcement officials approximated 41 miles

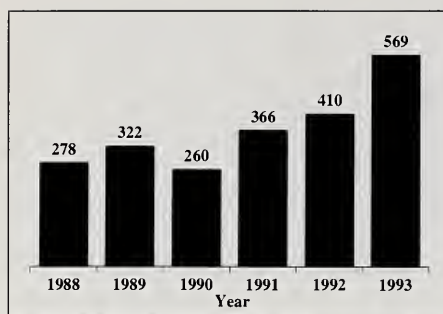


Figure 1—Snowmobile-related accidents in Minnesota as recorded by the State Department of Natural Resources. (Courtesy of Minnesota Department of Natural Resources.)

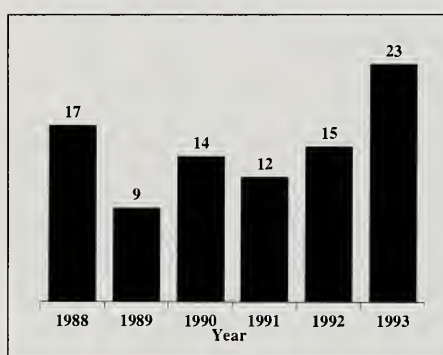


Figure 2—Snowmobile-related fatalities in Minnesota. (Courtesy of Minnesota Department of Natural Resources.)

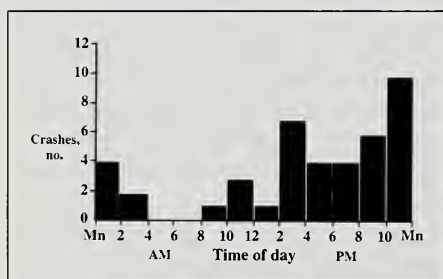


Figure 3—Timing of accident.

per hour (range, zero to 100 mph) as the average speed at the time of the accident. The cause of the accident was usually due to losing control of the snowmobile because of uneven terrain or collision (see Table 1).

Patients' presentation and symptoms varied along with the indications for hospitalization: bone fracture in 18 patients, blunt abdominal trauma in nine, closed head injury in five, cellulitis in five, lacerations in three, hypothermia in one, and frostbite in one. Most patients had no neurologic deficit (Glasgow Coma Scale, 15 in 90% of patients), despite

an initial loss of consciousness in 10 (four wore helmets and six did not).

Although 12 patients admitted they had consumed alcohol recently, an increased alcohol level was documented in only eight of 24 patients tested (mean level, 698 mg/mL; range, 100 to 1,217 mg/mL). Plain radiographs were made in all 42 patients, as well as multiple computed tomographic scans (head scans in 11, chest scans in two, and abdominal scans in 14). Radiography documented extensive orthopedic fractures ($n=34$) in 24 patients: lower extremity, 11 fractures; face, five; rib, five; vertebral body, five; pelvis, four; upper extremity, three; and scapula, one.

The mean Injury Severity Score (ISS) was 9.3 (range, one to 43; median, nine). The ISS adds the squares of the point values given for a trauma patient's three worst injuries (i.e., $a^2 + b^2 + c^2 = \text{ISS}$). Injuries from seven different body regions (head, neck, abdomen, pelvis, thorax, extremities, external tissues) are standardized and scored from minor (one point) to critical (five points). Young patients (aged 15 to 44) will not survive 50% of the time if the ISS is ≥ 40 ($\text{LD}_{50}=40$). The 26 emergent operations our facility performed were for injuries of the extremities in 10 patients, soft tissues in four, spleen in three, face in three, intestine in two, pelvis in two, liver in one, and profound hypothermia in one. Five patients required subsequent reoperation for bone/soft tissue debridement, orthopedic manipulation, or both.

Postoperatively, nine patients were admitted to our intensive care unit (mean, three days; range, one to five days). The severely hypothermic patient (core body temperature of 23.9°C) died of cardiac dysrhythmia despite rewarming via femoral-femoral bypass. Mean hospital stay for the entire group was six days (range, one to 16 days). Thirteen patients had complications: superficial wound infection in seven, ileus in three, cardiac dysrhythmia in one, compartment syndrome in one, and sacral decubitus in one. Five of the superficial wound infections were the reason for admission. After previous treatment of laceration at our institu-

tion ($n=2$) and by others elsewhere ($n=3$), these patients developed cellulitis. Long-term follow-up has detected the formation of one trauma-related cataract, nonunion of a radial forearm fracture, and near-complete resolution of three separate brachial nerve plexopathies.

Medical charges for acute care during hospitalization totaled \$569,566 (see Table 2). This total does not include medical transport or long-term rehabilitation charges. Thirty-three employed adults required a total of 308 weeks (mean, 9.6 weeks; range, three days to 26 weeks) of recuperation or rehabilitation before returning to work. A minimum loss of \$52,360 (308 weeks \times 40 hours/week \times \$4.25/hr) pales in comparison with the loss of life and 32 years of likely employment involving our single fatality. Third-party payers made consistently prompt payments, but because five patients (12%) did not have insurance and several others did not pay their entire bills, Mayo Clinic did not recover \$27,939 of the patients' medical charges (5%).

DISCUSSION

The care and cost of snowmobile-related injuries is considerable. Although several reports of snowmobile-related trauma have been published,²⁻⁹ the general public, politicians, and most physicians do not appreciate the significance of these winter accidents. Typically, most patients are young men injured after sunset because they are speeding over undulating or unfamiliar terrain. Many have been drinking. The current trend of snowmobilers bar-hopping in groups means that such accidents often have witnesses, and the injured receive medical care quickly. Lower extremity fracture is typical, and hospitalization, though relatively short, is expensive; frequently rehabilitation is long.

Our study is unique in documenting a high incidence of wound infection after soft tissue injury sustained with snowmobile trauma. James et al. noted that 8% of their patients developed complications, most of them due to wound breakdown.⁹ Seven of our patients (17%) had super-

Table 1

*Causes of 41 snowmobile accidents**

Cause	Number
Loss of control because of terrain	20
Collision with	
Snowmobile	5
Automobile	5
Tree	3
Fence	3
Equipment malfunction	2
Inner tubes	2
Open water	1
Total	41

*Because one accident involved two persons, total number of persons injured was 42.

ficial wound infections, all of which were treated successfully with antibiotics given intravenously, by opening the wound, or both. Only two of these patients had postoperative complications (7.7%). The five other patients had frank cellulitis after outpatient suture repair of lower extremity lacerations (two patients were treated at Mayo Clinic and three elsewhere). All seven patients with superficial wound infections were young men (age range, 16 to 40 years) injured at speeds greater than 20 mph. Our study confirms that proper wound management, especially for blunt injuries with crushed or lacerated tissue, involves careful debridement and removal of devitalized tissue before primary closure.

The human and financial costs of such accidents to society are immense. The one death that occurred among our patients involved a young mar-

Table 2

Gross and mean charges (in dollars) to 42 injured patients

	Gross	Mean
Hospital care	\$88,336	\$2,103
Pharmacy	40,418	962
Emergency room	42,772	1,097
Operating room	82,968	3,073
Radiology	49,952	1,218
Laboratory	54,361	1,469
Respiratory services	9,218	461
Outpatient services	7,818	191
Physical therapy/occupational therapy	6,664	417
Miscellaneous	5,478	913
Total hospital charges	\$387,985	\$11,904
Clinic charges*	\$181,581	\$4,323
Total charges	\$569,566	\$16,227

*Includes physician, pathology, administrative, and other charges.

ried man with several dependent children. He was returning home from a tavern on a night when the temperature was -15°F (-33°F windchill). Traveling at a speed of about 55 mph, he struck terrain that sent him and his 600-pound machine airborne for 75 feet. When he was found comatose eight hours later, his core body temperature was 23.9°C, and

all four extremities were frozen. Even though his medical care included a variety of life-saving measures, from rewarming by femoral-femoral bypass to extremity fasciotomies and eventual intrathoracic cardiac massage, he died. Such fatalities are infrequent within the confines of a medical center because most patients dying of snowmobile-related acci-

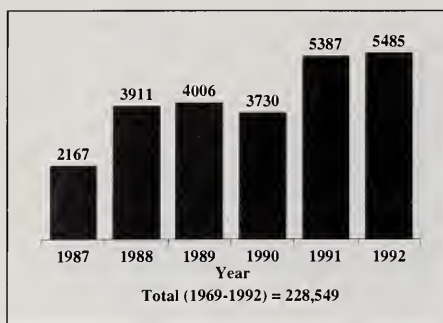


Figure 4—DNR snowmobile safety certification in Minnesota.

dents never reach medical care. Snowmobile-related accidents and fatalities have increased in recent years in Minnesota, with 50 snowmobile-related deaths from 1991 to 1993 (see Figures 1 and 2). Illinois has also had a marked increase in snowmobile-related fatalities recently.¹⁰

States need to tighten and enforce snowmobiling laws. Currently, the State Department of Natural Resources (DNR) handles Minnesota regulations for snowmobile use,

and county law officials enforce infractions. In Minnesota, anyone may drive a snowmobile without a helmet and at unlimited speeds with a registered vehicle on private property. The speed limit is 50 mph on state trails or over frozen water. Helmets are not required. To cross roads or to use state trails, children under 16 years need to complete a snowmobile safety course the DNR sponsors. More than 1,400 volunteers teach the course to 5,000 students annually (see Figure 4), and more than 228,000 people have completed the 27-year-old program successfully. Nevertheless, 82% of fatal snowmobile accidents in Minnesota during the last three years involved drivers who didn't have a snowmobile safety certificate. Clearly, all snowmobile drivers and passengers, including visitors to Minnesota, should be required to complete the safety course.

Nearly 17% of our hospitalized patients were 15 years old or younger, including a 7-year-old girl who

needed operative reconstruction of an orbital fracture after her snowmobile collided with a tree. The number of snowmobile accidents in Sweden decreased once the country required drivers to be at least 16 years old and outlawed driving on or near roads.⁵ Similar changes to Minnesota laws would save lives.

While law enforcement officials may not be able to consistently enforce snowmobile driving infractions throughout the state, officials can spot-check along trails and lakes. Strict enforcement of regulations and education at an early age seem to be the two most efficacious methods of reducing snowmobile accidents and trauma. It is unfortunate that humans continue to hurt themselves on snowmobiles. After treating one young male patient for multiple orthopedic fractures after his 100 mph attempt at crossing open water, we believe that even our precautionary suggestions won't eradicate all thrill-seeking behavior. **MM**

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REFERENCES

1. Minnesota Department of Natural Resources. Snowmobile accident report. St. Paul, Minnesota: Minnesota Department of Natural Resources, 1993.
2. Reid DC, Saboe L. Spine fractures in winter sports. Sports Med 1989;7:393-9.
3. Keene JS. Thoracolumbar fractures in winter sports. Clin Orthop 1987;216:39-49.
4. Hedberg K, Gunderson PD, Vargas C, Osterholm MT, MacDonald KL. Drownings in Minnesota, 1980-85: a population-based study. Am J Public Health 1990;80:1071-4.
5. Bjornstig U, Eriksson A, Mellbring G. Snowmobiling injuries: types and consequences. Acta Chir Scand 1984;150:619-24.
6. Hamdy CR, Dhir A, Cameron B, Jones H, Fitzgerald GW. Snowmobile injuries in northern Newfoundland and Labrador: an 18-year review. J Trauma 1988;28:1232-7.
7. Rowe B, Milner R, Johnson C, Bota G. Snowmobile-related deaths in Ontario: a 5-year review. Can Med Assoc J 1992;146:147-52.
8. Eriksson A, Bjornstig U. Fatal snowmobile accidents in northern Sweden. J Trauma 1982;22:977-82.
9. James EC, Lenz JO, Swenson WM, Cooley AM, Gomez YL, Antonenko DR. Snowmobile trauma: an eleven-year experience. Am Surg 1991;57:349-53.
10. Burgas F. Snowmobiling deaths up, law to curb drunken drivers considered. Chicago Sun Times 1994 January 23.

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Life Expectancy, Life Span, and the Limits of Medicine

How long can we expect to extend a person's life, and at what cost to quality living?

Seymour Handler, M.D.

Physicians rarely consider the relevance of life expectancy to their professional work. After all, the physician-patient relationship involves an implied contract, under which the physician advocates for the patient's health care needs, regardless of age or life expectancy. The physician treats one patient at a time, not a whole population. Even the goals of medical care—to prolong life and to improve the quality of life—give scant attention to how long a person can reasonably expect to live. Physicians use treatments such as joint replacement, pneumonia therapy, and coronary artery angioplasty to extend a patient's life. To enhance quality, physicians add such subjective ingredients as reassurance, counsel, and emotional support.

Yet, with life and quality of life at the center of the contract between physician and patient, physicians need also to consider life expectancy. How long can we expect to extend a person's life? What are the medical limits in doing so? If we cross the boundary of what we can readily do to extend the length and usefulness of a patient's life, we simply raise the cost of medical care and accomplish little that benefits the patient.

The current health care trend is to give people what they want and push to the limit medical technology, without regard to cost-benefit considerations. Before we break the bank, we need to look closely at how much we are willing to spend on health care. We also need to address the question, What are the limits of medicine?

In the following discussion, I cover life expectancy at birth and the factors that contribute to its variability at different ages and in different situations. I also look at the philosophical concept of maximum attainable life span and distinguish life span from life expectancy. Finally, I consider the limits that life expectancy and life span impose on modern medicine.

LIFE EXPECTANCY

Life expectancy at birth is defined as the average age of death in a population in a given time interval, usually one year. Life expectancy at birth in the United States has dramatically increased since 1900.¹ That year forms the

base for comparison because before then, only the census taker collected data about cause of death. Since 1900, the U.S. Death Registration System has gathered more reliable mortality data.

Life expectancy for white people at birth increased from 48 to 75 years between 1900 and 1990—a difference of 27 years. Since 1900, life expectancy at age 45 improved from 24 to 31 years, only a seven-year increase. And, if a person reached age 85 in 1990, life expectancy was barely better than in 1900.² Therefore, much of the significant improvement in overall life expectancy has occurred early in life.

MORTALITY BY DISEASE

Peery's report describes death from all causes from the turn of the century (see Figure 1). Total mortality from all causes (not age-adjusted) was 1,700 per 100,000 population in 1900 and declined to 950 per 100,000 in 1969. Note that almost half of all deaths (800) were due to infectious disease in 1900, declining to less than 100 in 1969 (see Figure 2). During that 70-year period, degenerative diseases and malignancies replaced infectious diseases as the leading causes of death.¹

Improved mortality rates in neonatal and pediatric age groups are predominantly due to better control of infectious disease. Much of this improvement occurred in the first half of the century; since 1950, pediatric mortality has flattened out. Since there is very little room for improved mortality in these age groups, spending a lot of money and energy to prolong life would yield little. How much can or should be done in therapy of very premature infants in NICUs, where costs mount dramatically to achieve minute improvements in mortality, but where chronic neurologic and pulmonary morbidity in the survivors is part of that cost?

OTHER FACTORS INFLUENCING LIFE EXPECTANCY

Besides disease, several other factors influence life expectancy, such as gender, national origin, cigarette smoking, and diet.³ Social factors that may affect life expectancy include education and lower birth rates.

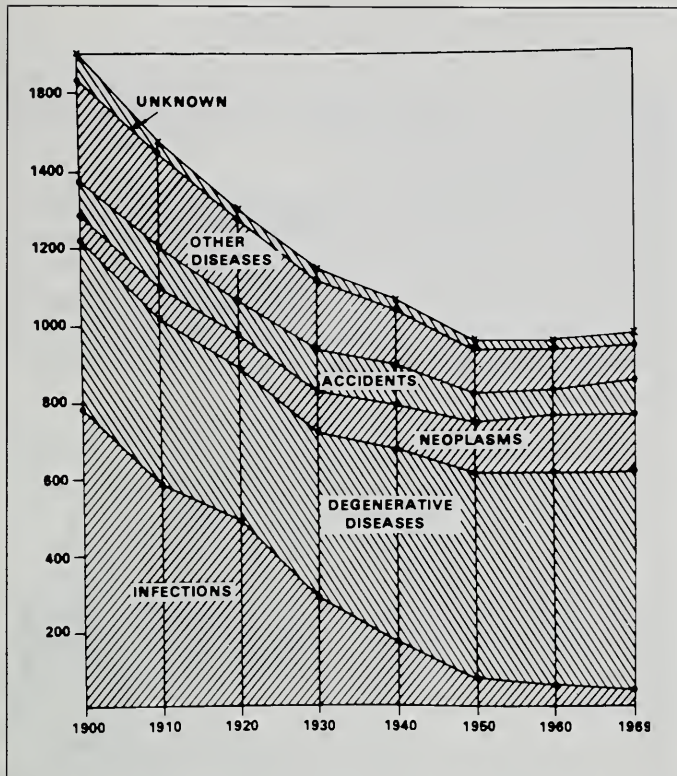


Figure 1—Representation of death rates per 100,000 people in the United States from all causes, 1900 to 1969. Reprinted with permission from the American Journal of Clinical Pathology 1975;63:458.

Life expectancy differs by gender. U.S. women live seven years longer than men, and smoking, work, food, shelter, sanitation, or health care do not account for the difference. Until about 150 years ago, women's life span was shorter than or identical to that of men. Semmelweis's hygienic improvements in the mid-19th century resulted in the decline of puerperal sepsis and accounted for some of the decrease in young female mortality (although most women continued to deliver babies at home, where the risk of puerperal sepsis was lower). As society has lessened the risks associated with childbirth, it has also reduced the risk of death for women. For unknown reasons, this allows women to survive longer than men.

National origins have a major impact on life expectancy.³ Japan and Chad represent the extremes of longevity, where average life expectancy is 78 years and 36 years, respectively. Tremendous differences exist between Western nations and several Pacific Rim nations and the Third World.

Cigarette smoking definitely contributes to premature mortality.⁴ Cigarette smoking is said to cause 400,000 excess deaths per year in the United States. The important question is, Does cigarette smoking itself cause premature death, or do other factors in those who choose to smoke cause premature death? Studies of identical twins reared apart clearly indicate that cigarette smoking is the major factor in reduced longevity. Evidence substantiates that cigarette smoking by itself kills.

With diet, the influence on life expectancy is less clear. Until recently, Japan's citizens had diets low in

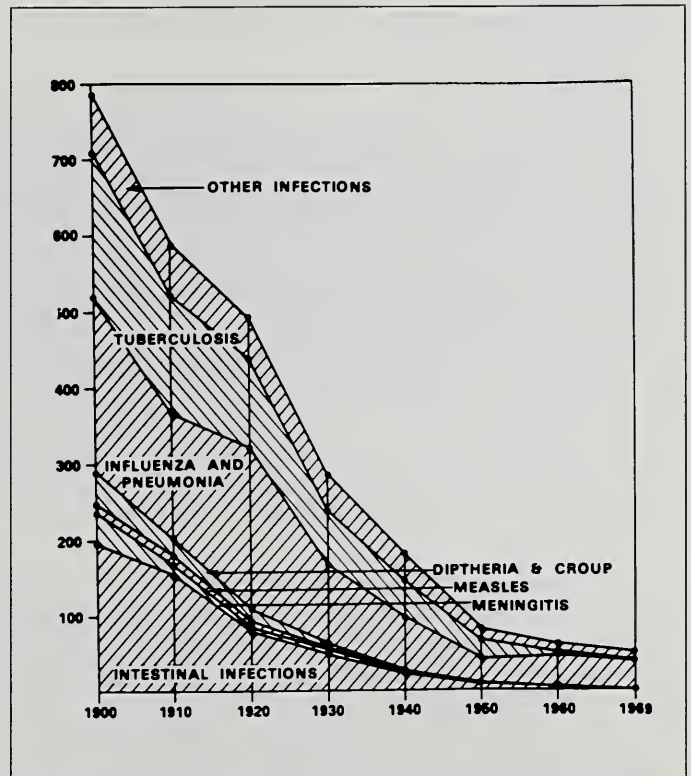


Figure 2—Death rates from infectious disease, United States, 1900 to 1969, by major types. Reprinted with permission from the American Journal of Clinical Pathology 1975;63:459.

saturated fat, whereas the people of Switzerland and Austria have diets high in fat.³ The three countries report similar longevity. Adequate calorie intake, which these nations report, may impact longevity more than saturated fats.³

What impact do social factors have on life expectancy? Japan, where births to unmarried women account for less than 1 percent of all births, and Sweden, where 50 percent of births are to unmarried women, have similar longevity.

What about the cost of health care? The United States has the most expensive health care in the world; Germany and Japan spend about half as much; Greece about one-tenth as much. Yet all these nations report comparable longevity. Indeed, health care cost appears to have little effect on life expectancy. Instead, more education and resulting lowered birth rates make up part of the common denominator of increased longevity.

Researchers have debated the value of long-lived parents to an individual's longevity⁵ but have not identified a longevity gene. Most authorities believe that multiple genes are involved. Although individuals born to long-lived parents live somewhat longer than average, the relationship is not clear.³ Factors such as education, income, social status, and residence are difficult to separate from inheritance factors. Nevertheless, work by Hawkins,⁵ further studied by Pearl,⁶ suggests that life expectancy is increased for people whose parents live long lives. How can one join the long-lived group? Have good health, be employed, don't

smoke cigarettes, be female, and, of course, have long-lived parents.

LIFE SPAN

Whereas mortality statistics are used to calculate life expectancy, life span is far more difficult to measure. A vigorous debate has occurred between those who believe humans have a maximum life span no matter how much disease medicine conquers and those who believe that the human life span can be incrementally increased by conquering disease.^{7,8} The majority view favors a finite life span, buttressed by the constant number of centenarians per increment of population. Moreover, researchers have proved untrue the longevity claims from the Russian Caucasus and Greece.⁴ In studies of those countries, people lied about their age for social advantage, either to avoid military conscription in Russia or because Greece venerates elders.

The oldest documented age of death is 116 or 120 years.^{5,6} Even with our progress in fighting disease and increasing life expectancy, the extreme parameters of old age remain unchanged. The work of Hayflick with human fibroblasts noted a finite number of divisions before the fibroblasts quit dividing and died, and without apparent disease.⁹ Fries postulated a human life span of 85 years based on his observations of life expectancy during this century.¹⁰

LIMITS OF MEDICINE

If we accept the concept of a finite life span and the prediction of an 85-year life span, where 95 percent of people die somewhere between 75 and 95 years,⁸ then we can begin to appreciate how close we have come in this country to the limits of medicine. For white women in the United States, the current life expectancy of 79 years approaches the maximum attainable life span.

Mortality studies indicate we have come to the limits of significant progress in treating fatal disease in young people. If we eliminated all deaths of people under age 50 (12 percent of all deaths), life expectancy at birth would increase 3.5 years.¹¹ If we eliminated all deaths due to cancer (24 percent of all deaths), we would increase life expectancy only 2.3 years. The reason for this apparent paradox? The theory of competing risks implies that a cure for cancer only changes the cause of death, not the life expectancy of the population.¹² The theory suggests that when a doctor cures an 80-year-old patient of one fatal disease, the patient will likely die of another quite soon. Physicians who cure a patient's disease at an advanced age modify that patient's life expectancy very

little. Only the cause of death changes.

Though flawed, this theory has gained support. The Framingham study noted a decrease in deaths due to stroke but a rise in colon cancer deaths. Improving the outcome from one disease causes a relative increase in cases of another disease.

What do we hope to gain by medical science achieving longer life expectancy, approaching the theoretical maximum life span? Do we create a population of the very old who are frail, senile, dependent, and living in nursing homes? Is this what we want, or should we be satisfied with a shorter life, but one that is vital, fulfilling, and independent?

If the human life span is finite, then conquering disease in the aged is a fruitless endeavor. Olshansky points out that a natural senescence occurs in old people, to the point where the tiniest insults, which seem trivial to the young, are sufficient to cause death. He believes that the frailty of age, not disease, kills very old people.¹¹ If biologic senescence is a fact of life, then our attempts to conquer disease in old patients yield neither longevity nor quality of life. We only postpone the inevitable.

MM

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REFERENCES

1. Peery TM. The new and old diseases: a study of mortality trends in the United States, 1900-1969. *Am J Clin Path* 1975;63:453-74.
2. Statistical Bulletin 1991 July-September:19-25.
3. Moore TJ. Lifespan: who lives longer and why. New York: Simon and Schuster, 1993:73.
4. Preston SH. Biological and social aspects of mortality and the length of life. Liege, Belgium: Ordina Editions, 1980:443-5.
5. Hawkins MR. Inheritance and longevity: a study of offspring of nonagenarians. *Bulletin of Johns Hopkins Hospital* 1965;117:24.
6. Pearl R. The ancestry of the long-lived. Baltimore, Maryland: Johns Hopkins Press, 1934:320-1.
7. Fries JF. The compression of morbidity. *Milbank Q* 1989;67:208-32.
8. Olshansky S, Carnes J, Cassell C. Methuselah: estimating the upper limits of human longevity. *Science* 1990;250:634-40.
9. Hayflick L. The cell biology of human aging. *Sci Am* 1980;242:58-65.
10. Fries JF. Aging, natural death, and the compression of morbidity. *New Engl J Med* 1980;303(3):130-5.
11. Olshansky JJ. How long is the human life span? *Science* 1991; 254:936-8.
12. Maloney JV. The limits of medicine. *Ann Surg* 1981;194: 247-55.

The Psychology of Wellness

Blending Biomedicine, Belief, and Alternative Care

The books "Timeless Healing: The Power and Biology of Belief" and "Manifesto for a New Medicine: Your Guide to Healing Partnerships and the Wise Use of Alternative Therapies" remind us that medicine is more than science.

Charles R. Meyer, M.D.

Don't better, feelin' worse. This may be the epitaph for high-tech medicine in the waning days of the 20th century. Practicing physicians have repeatedly seen patients who survive acute or chronic illnesses only to tumble into life-numbing depression or anxiety. After 50 years of unequaled therapeutic and diagnostic advances, 1996 finds medicine challenged by the flight of patients to alternative medicine. Even as MRIs proliferate and drug companies pump out more miracle drugs, health food stores are healthier and Deepak Chopra is wealthier.

What's this trend all about? Is it a wave of slick public relations and mass befuddlement, or is it a fundamental failing of scientific medicine? Two recent books form part of the core curriculum for this movement: "Timeless Healing: The Power and Biology of Belief," by Herbert Benson, M.D. (Scribner, 1996) and "Manifesto for a New Medicine: Your Guide to Healing Partnerships and the Wise Use of Alternative Therapies," by James S. Gordon, M.D. (Addison-Wesley, 1996).

Benson, a Harvard-trained psychiatrist, emerged as a media star in 1975 when his book, "The Relaxation Response," dominated the best-seller list for weeks. The book documented a scientific tie between psychological stress, physiological changes, and physical symptoms. Through meditation, tapes, and other aids, Benson directed readers to achieve the relaxation response as a

way to ease stress and improve health.

"Timeless Healing" draws on Benson's work at Harvard's Mind/Body Medical Institute. In his latest book he describes a search for healing that endures, for health that eclipses surgical or medical cure. He calls this concept of healing "remembered wellness" and defines it as a "scientifically profound source of healing ... the calm and confidence associated with health and happiness, but not just in an emotional or psychologically soothing way. This memory is also physical."

Belief—of the caregiver and the patient—is the foundation of this type of healing. This is the placebo effect, but it is more than just sugar pills. "In large measure," writes Benson, "the history of medicine is the history of the placebo effect. ... Ironically, the reputation physicians have enjoyed throughout history ... was built on and cultivated by the success of remembered wellness and on the three modes of belief-inspired healing: the belief of an individual in a treatment, the belief of the caregiver, or their mutual beliefs." Benson uses the paradigm of a three-legged stool to explain the healing relationship. Pharmaceuticals, surgery and procedures, and self-care are the "legs" that support the seat of health and well-being. Scientific medicine has neglected self-care, where belief and emotion are so important.

Benson's prescription for doctors and patients contains three ingredients: 1) identify each other's impor-

tant beliefs and motivations, 2) discuss and act on those beliefs, and 3) let go and believe. Religious belief and faith are the vehicles for his prescription.

Like Benson, Gordon is a psychiatrist who runs a mind-body center—the Center for Mind-Body Medicine at Georgetown University in Washington, D.C. He also begins his book with an analysis of scientific medicine's deficiencies. The "biomedical model," as he labels it, shines in treating acute illnesses but flops when addressing chronic disease because it "conceives of illness as a product of heredity, as the outcome of a string of predictable causative factors, or as an unfortunate aberration." This formulation leaves little or no room for the unmeasurable influence of emotion. "Virtually every chronic illness has a powerful psychological component, and almost always, the work of untangling the fears, resentments, and misconceptions that prevent emotional and intellectual change is a necessary precondition for physical healing." In the biomedical model, according to Gordon, tests and data subvert the physician-patient relationship and the physician's comprehensive understanding of the patient.

Gordon's answer to the biomedical model is the healing partnership between doctor and patient. Invoking ancient concepts of caring communities and the power of meditation, Gordon takes the reader on a peripatetic romp of alternative therapies like massage, acupuncture, and

Chinese herbal treatments. Lacing his analysis with anecdote and narrative, Gordon outlines his definition of holistic medicine—a balance of self-help techniques like diet, relaxation, and exercise; alternative professional remedies; and, for “special-

ly demanding and threatening situations,” traditional medicine and surgery.

These books are easy reading but not easy swallowing. Much of what both authors say goes against classical medical school teaching.

Gordon's book, in particular, strains credibility with its reliance on stories of miraculous recoveries and self-experimentation as proof of efficacy. Graduates of Degowin & Degowin's physical exam book will wince at this description: “I look at the coating of the tongue—if the illness is hot and acute, it is likely to be yellow; if cold and chronic, then white—and check for the tight lumpiness of qi and blood stagnation in my patient's belly as attentively as I might listen for a murmur in her heart or feel for enlargement of her liver.”

Yet these books contain much truth. Physicians who practice medicine but don't acknowledge the illness-producing power of stress and fear and the healing power of trust and faith haven't really been looking at or listening to their patients. Physicians who think biochemistry and molecular biology describe all we see in the clinic and hospital need to review their last 20 patients. And physicians who think scientific medicine or the biomedical model has all the right answers suffer from a hubris that comes from ignoring the history of medical ignorance.

Gordon and Benson's core curriculum is worth studying. Perhaps blending scientific methods and alternative care with a core of belief's healing power will lead future patients to say “feelin' better” even though they might be doin' worse. MM

Charles Meyer is editor-in-chief of Minnesota Medicine and an internist with Consultants-Internal Medicine in Minneapolis.

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- ____ *"It's OK to talk to me about family violence and abuse" buttons:* \$25.00 per 25; \$37.50 per 50; \$50.00 per 100.
- ____ *Stop the media violence resource guide for physicians:*
Introduces media violence as a part of a public health epidemic and suggests ways for physicians to help. No charge.
- ____ *10 Tips for parents to stop the media violence:*
Contains 10 ways to assist parents in regulating television viewing in the home. \$10.00 per 50; \$15.00 per 100.
- ____ *Unload It & Lock It:* Contains firearm safety checklist. \$15.00 per 50; \$20.00 per 100.
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VISIT THE MMA HOME PAGE

The Minnesota Medical Association Web page includes information on MMA legislation and advocacy, news, a staff directory, related organizations, discussion groups, CME information, and links to the best clinical resources and products and services. Visit the MMA home page at: www.mnmed.org

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MMA RECEIVES ROBERT WOOD JOHNSON GRANT

The Robert Wood Johnson Foundation has awarded a \$20,000 grant to the Minnesota Medical Association, the Minnesota Public Health Association, and the Center for Population Health to fund a joint conference on collaborative efforts between medicine and public health in Minnesota. The proposed conference will build on the American Medical Association/American Public Health Association "Medicine/Public Health Initiative." For more information, call Janet Silversmith, MMA health policy analyst, at 612/378-1875 or 800/999-1875.

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MEMBERS ARE NEEDED FOR RCBs 2 AND 5

The MMA is seeking nominations for an MMA-appointed member and alternate to the Regional Coordinating Board 2, which covers the entire MMA northeast trustee district, and for RCB 5, which includes the southwest MMA trustee district. If you are interested in serving on an RCB or in nominating another physician, call Steven Jahn at 612/378-1875 or 800/999-1875. Nominations are due by January 10. The MMA Board of Trustees will consider nominations at its February meeting.

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

Commission Supports Elimination of Provider Tax

The Minnesota Health Care Commission voted November 20 for a MinnesotaCare financing plan that would reduce the provider tax to 1 percent on January 1, 1998, and eliminate the tax by January 1, 2001. The commission plan recognizes that "existing funding mechanisms and taxes are inequitable and should be replaced with general fund revenues."

"The commission's action was a significant step that will help the Minnesota Medical Association's efforts to begin phasing out the provider tax," said David Renner, MMA director of policy and legislation. "We still face an uphill battle, but the fact that a broad cross section of health care stakeholders, including the state's major health plans, supported the phaseout is important."

The commission set a long-range goal of reducing the number of uninsured to 4 percent of Minnesota's population by the year 2000 and reaffirmed its commitment to expand the MinnesotaCare program to serve people who earn up to 275 percent of the federal poverty level (\$21,285 for an individual).

The commission set the following short-term goals in addition to reducing the provider tax: increase MinnesotaCare eligibility for individuals and families without children to 175 percent of the federal poverty level (\$13,545 for an individual) by July 1997, improve the pass-through, raise the cigarette tax 10 cents per pack, shift 5 cents of existing cigarette tax revenues from the General Fund into the Health

Care Access Fund, and change the financing system for the Minnesota Comprehensive Health Association (MCHA).

Finance Work Group Plan

Speaking as the rural physician representative on the commission, Raymond G. Christensen, M.D., proposed the provider tax reduction to the Finance Work Group. "Small rural clinics trying to remain independent have a dilemma—they can't handle the 2 percent tax," Christensen said. "In our Moose Lake Clinic we pay about \$26,000 in provider taxes. Generally, we aren't able to pass the tax through. We take in about \$26,500 in revenues from MinnesotaCare patients. So financially, it's a wash."

The Finance Work Group has been struggling for six months to reach agreement on a financing plan for the MinnesotaCare program. The MMA and others urged that the provider tax reduction be part of the package and opposed a controversial proposal to take approximately \$22 million from the Health Care Access Fund and \$6 million from the General Fund to finance MCHA, a state insurance program for people who have been denied insurance. Currently, MCHA costs that are not covered by enrollee premiums are funded by an assessment on regulated health plans. This assessment is not directly applied to self-insured companies. The commission plan would give a 1 percent offset of the premium tax to indemnity plans and

Provider Tax continued on page 35



Viewpoint

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Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

Which Is Better—For-Profit or Nonprofit HMOs?

Why is Minnesota the only state in the nation that does not allow for-profit HMOs?

With the 1997 legislative session fast approaching, the MMA may have to consider this question. The Insurance Federation and some employers would like to see for-profit HMOs come into Minnesota and this would require legislative approval.

The names "nonprofit" and "for-profit" are somewhat misleading. Both types of HMO make a profit, but they distribute their profits differently. In return for their tax-exempt status, nonprofits must meet specific charitable or social welfare requirements and may not give excess revenues to shareholders as for-profits do.

The key questions for the MMA are: Should for-profit HMOs be allowed? What impact would they have on Minnesota physicians and their patients?

Surprisingly, HMOs provide coverage to only 20 percent of Minnesotans. Self-insured health plans, Medicare, Medicaid, and commercial indemnity insurance arrangements cover the rest. Nevertheless, allowing for-profit HMOs in Minnesota could have a significant impact on the health care market.

One advantage of for-profits is that they would pay certain state taxes. Their supporters argue that because for-profit HMOs are ac-

countable to investors, they have to be more efficient and demonstrate higher quality. Presumably, they would create greater competition, lower prices, higher quality, and more choice for patients. But there is no evidence. There have been no studies comparing the efficiency or quality of for-profit and nonprofit HMOs. An AMA study found that for-profit HMOs spend more money on administration and profits for their investors and less on medical and health care services for their enrollees than nonprofit HMOs.

Opponents of for-profits fear that pressure to produce dividends for stockholders would create an incentive to restrict or deny medically necessary services. It may also intensify a tendency to cherry pick or seek to attract only healthy enrollees.

Some physicians support for-profit HMOs because they would create access to capital through stock offerings, thus making it easier for physician-owned HMOs to enter the market. Lack of capital has been a huge barrier to physician-sponsored networks. On the other hand, there is a danger that large, nationwide, for-profit HMOs would buy up Minnesota hospitals and clinics, create a monopoly in some parts of the state, and later raise their prices. Could physician-sponsored networks survive? Large for-profit HMOs might price competitors out of the market, leaving Minnesotans with only one choice—an unknown, out-of-state company.

MMA policy supports nonprofit integrated service networks and community integrated service networks. The MMA has taken no position on for-profit HMOs. MMA goals and principles support arrangements that serve our patients' best interests, promote public health, preserve the physician-patient relationship, encourage locally controlled care systems, and allow physicians autonomy in making decisions about patient care.

Which type of HMO is more in line with these MMA principles—an HMO whose mission is to generate a profit or an HMO that is required to provide a benefit to the community? We also ask: Do nonprofits really behave differently than for-profits? Are they fulfilling their mission to return benefit to the community? Do they justify their tax-exempt status and access to tax-exempt bonds? Some argue that nonprofits make huge profits, which they distribute to their executives, and pay no taxes. Greater accountability of these non-profits may be in order.

In my personal opinion, a well-regulated nonprofit HMO that meets its community service mission may be better able to meet MMA goals. For-profit HMOs might increase competition in the marketplace, but they won't improve access or move toward universal coverage. It may be better to stimulate competition in other ways such as encouraging physician-sponsored organizations, care systems, CISNs, cooperatives, and purchasing pools, and encouraging competition to provide a standard benefit set.

To return to our original question: Why is Minnesota the only state to ban for-profits? Possibly because of our state's strong tradition of providing for the health and welfare of the community. The MMA will continue to support an HMO market in Minnesota that is based on the principles of quality care, patient protection, charity, public good, and community benefit. Like all public policy issues, the profit versus nonprofit debate will require our continuing reevaluation and vigilance.

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Provider Tax continued from page 33

HMOs to use to pay the MCHA assessment.

The MCHA proposal is contingent upon shifting 5 cents of current cigarette revenues from the General Fund to the Health Care Access Fund.

After much discussion, the finance group approved its final plan and presented it to the commission later the same day.

Some commission members feared that relying on the general fund would jeopardize the MinnesotaCare program. "All the sharks swimming in the water at the Legislature will be going after money in the General Fund," said Jeff Bangsberg, representing citizens with disabilities.

"The Legislature and the governor are going to have to bite the bullet and provide money from the General Fund. The provider tax is

not going to be a sustaining source," said Steve Rogness, representing the Minnesota Hospital and Healthcare Partnership.

MMA representative Jasper Daube, M.D., voted in favor of the total package. Although the MMA opposes raiding the Health Care Access Fund to bail out MCHA, the total package would achieve major MMA goals.

Daube argued in favor of reaching consensus on the need for broad-based funding for the MinnesotaCare program. "We are dedicated to achieving universal access to basic health care. We can only get there by negotiating, compromising, and recognizing that we're all after the same goal. Nobody likes taxes. But health care is in the same category as education and should be funded the same way."

The final vote was 14-8. Voting for the proposal were representatives of the MMA, health plans, hos-

pitals, and employers. Voting against it were consumer groups, the state agencies, and the Minnesota Nurses Association.

Eligibility Increase

The commission's proposal to raise MinnesotaCare eligibility to 175 percent of the federal poverty level for individuals and families without children will face an uphill battle. Sen. Linda Berglin, DFL-Minneapolis, told the commission that the MinnesotaCare program would face a structural deficit by the year 2000 if eligibility were increased to 175 percent of poverty, but not if it were raised to 165 percent. Her projection does not take into account the current surplus in the Health Care Access Fund. Last year, Gov. Arne Carlson vetoed a proposal to increase eligibility to 150 percent and instead raised eligibility to 135 percent.

Pass-Through Fix

The financing package would amend MinnesotaCare legislation to give the commissioners of commerce and health the power to enforce the pass-through of the 2 percent tax by fining or retracting the license of health plans that refuse to pay. The proposal does not, however, address the fact that there is no standard method for remitting the 2 percent tax to the physicians and no way to verify whether the tax is being paid by the health plans and insurers.

Cigarette Tax

The commission plan to redirect 5 cents per pack of the current tobacco tax would transfer about \$18 million out of the General Fund into the Health Care Access Fund. This would be used to cushion the effects of the reduction in the provider tax and the loss of revenue resulting from the transfer of the 1 percent HMO/Blue Cross Blue Shield premium tax into the General Fund. The 10-cent per pack increase in the tobacco tax would raise approximately \$34 million for the General Fund to be used for medical education and public health initiatives.

MMA Honors Service to Minorities

The Minnesota Medical Association presented the MMA Award for Meritorious Service to Minority Populations to Fredrekia Lewis, M.D., at the Minnesota Medical Association's 143rd Annual Meeting.

Fredrekia Lewis, M.D., has been in solo practice in internal medicine in the Twin Cities for 14 years. His diverse practice includes patients of all races and economic conditions. He has served as medical director of the Model Cities Health Center and as assistant chief of internal medicine at the former Mt. Sinai Hospital. Lewis is active in the Pilot City Health Center and in programs to assist senior citizens. In addition, he volunteers his time to the Golden Gloves boxing program and the American Cancer Society. Lewis has been involved in the internship program for medical assistants in his clinic and at the Model Cities Health Center and has helped medical assistants find permanent employment.

MMA Presents Sova Award to Rep. Cooper

The Minnesota Medical Association presented the James H. Sova Memorial Award to Rep. Roger Cooper, DFL-Bird Island. The James H. Sova Award is given to a person not of the medical profession who has made a significant contribution to the advancement of medical sciences, medical education, medical care, or the socioeconomics of medical practice.

During his 10 years in the Minnesota House of Representatives, Cooper helped pass legislation to improve access to health care and emergency medical services, particularly in rural Minnesota. Cooper helped develop the MinnesotaCare program and later helped pass legislation to expand MinnesotaCare eligibility and to repeal the regulated all-payer option, which he believed would undermine access to health care in rural Minnesota.

MMA Honors Physicians for Community Service

The Minnesota Medical Association presented the 1996 Physician Awards for Community Service to the following physicians: Raymond J. Lindeman, M.D., of Paynesville; William D. Manahan, M.D., of Mankato; John M. Thomas, M.D., of Paynesville; and Paul T. Wicklund, M.D., of St. Paul. The MMA Community Service Awards honor physicians who have performed outstanding service to their communities in addition to their practice of medicine. The awards were presented at the MMA's 143rd Annual Meeting.

Raymond J. Lindeman, M.D., a family physician at Paynesville Medical Center, was a member of the Paynesville School Board for 17 years. He served as chief of staff at Paynesville Community Hospital and was instrumental in forming the Paynesville Area Community Health Sys-

tem, a physician-hospital organization. A charter member of the Paynesville Lions Club, Lindeman served as district governor of Lions International. During his free time, Lindeman is a woodworker and has donated many hand-crafted items to local fundraising activities.

William D. Manahan, M.D., a family physician at the Mankato Clinic, has volunteered many hours of medical care in Africa, Hawaii, and inner-city Boston. Manahan is known to his colleagues as an excellent educator, writer, and physician.

John M. Thomas, M.D., a family physician at Lutheran Health Systems in the Fargo/Moorhead area, helped start the Fargo-Moorhead migrant health program while he was in medical school. As Clay County medical consultant, he helped initiate a number of public health pro-

grams. He served as Moorhead and as Clay County medical examiner and health officer, running the local family planning clinic, assisting in rotations at the Migrant Health Clinic, and providing health care to inmates at the Clay County Correctional Facility. He also served as the medical director of the Clay County Public Health Department and the public health nursing program and was a member of the Moorhead City Council.

Paul T. Wicklund, M.D., an orthopedic surgeon at Capitol Orthopedics in St. Paul, has helped build a partnership between Minnesotans and Ukrainians. In 1991, after an initial visit to the Ukraine, Wicklund organized the Shepherds Foundation, which has sent several hundred Minnesotans to the Ukraine to participate in medical, dental, educational, and agricultural programs. Medical teams provide medical consultation, introduce surgical and medical techniques, and donate badly needed medical equipment and supplies.

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MMA Stop the Violence Day at the Dome Plants Seeds of Peace

• • • • • THE FOLLOWING ARTICLE appeared in *The Initiator*, the newsletter of the Initiative for Violence-Free Families.

At times it is difficult to know whether our work in preventing violence actually pays off or makes a difference. Ryan Borgen, an eighth-grader at Twin Bluff Middle School in Red Wing, attended Stop the Violence Day at the Dome and saw her efforts have an immediate impact. Ryan and her family attended the Twins game because of the special Stop the Violence Day promotion and were enjoying the game when they noticed a man nearby yelling at and physically restraining his son, who seemed to be about 12 years old.

"The man was really swearing at him and pushing him down hard in his seat," said Ryan.

Ryan and her family grew increasingly uncomfortable with the situation as the game went on, and Ryan finally asked her mother if it would be OK if she said something to the man. "At first I hesitated, but we were all so upset about the way he was treating the boy, so I told Ryan to go ahead," said Cindy Borgen, Ryan's mother. "Ryan has picked up a lot of conflict resolution skills from her friends at school who've been trained in peer mediation."

As the man came down the aisle from the concession stand, Ryan asked him if he knew that today was Stop the Violence Day at the Dome. "He asked me why I brought it up

and said he wasn't violent," Ryan said. "I explained to him that violence isn't just hitting people but that yelling and swearing is also violence. He said that the boy was acting up and that he needed to yell at him to keep him in his seat. He told me I'd understand better when I had kids. But I told him that I thought violence just creates more violence."

Ryan's mother noted that after the man went back to his seat he seemed to interact more with his son and stopped yelling at him. "He paid more attention to the boy, and they both seemed to settle down."

As the fans filed out of the stadium after the game, the man came up to Ryan. "He thanked me for bringing it up to him and then he moved on," Ryan said. "It made me feel that I really made a difference."

MMA Appeals to U.S. Supreme Court

A petition has been filed asking the U.S. Supreme Court to consider the Minnesota Supreme Court's dismissal of the appeal of the lawsuit charging that the retroactive application of the \$400 surcharge on physicians' medical licenses was unconstitutional. The class action by more than 5,000 physicians whose medical licenses were issued or renewed from April 1 to September 30, 1992, sought refunds of the \$400 surcharge. The

physicians argued that it was illegal for the state to require them to pay the surcharge because the tax law did not take effect until October 1, 1992. They charged that the retrospective application of the tax violated their constitutional guarantees of due process and equal protection. The MMA has been actively involved in this case, helping identify the plaintiff physician class and assisting with coordination. •••••

AMA Files Assisted-Suicide Brief

The American Medical Association filed an amicus brief in the Supreme Court case opposing physician-assisted suicide. The Supreme Court has taken two cases, from the 9th and 2nd U.S. Circuit Courts of Appeals, both of which raise the question of whether there exists a constitutional right to physician-assisted suicide.

The AMA brief affirms that the 9th Circuit Court of Appeals was wrong in announcing a constitutional right to control the timing and manner of one's death through the use of physician-assisted suicide and argues that this would "create profound danger for many ill persons with undiagnosed depression and inadequately treated pain for whom assisted suicide rather than good palliative care could become the norm. At greatest risk would be those with the least access to palliative care—the poor, the elderly, and members of minority groups." •••••

Idaho Court Rules Against Optometrists on Laser Surgery

In a victory for physicians, an Idaho District Court ruled that photorefractive keratectomy (PRK) constitutes surgery and can be performed only by optometrists who are also licensed physicians. The court noted that because using lasers in treating eye disorders permanently changes human bodily tissue, it is an invasive procedure that need not be differentiated from surgery using a knife. The Idaho Medical Association, the Idaho Society of Ophthalmology, and the American Academy of Ophthalmology successfully brought the lawsuit against the Idaho Board of Optometry.

The court also ruled that the Idaho State Board of Optometrists' "interpretation" of the state optometry act to include the use of lasers in optometric scope of practice was, in fact, rulemaking and subject to state rulemaking procedures.

The Idaho Board of Optometry intends to appeal the district court's ruling to the Idaho Supreme Court. The AMA notes that any clear grounds on which the defendant could base an appeal are not apparent at this time.

Idaho optometrists may try to expand their scope of practice at the state Legislature, but lawmakers are likely to consider the actions of other states. Currently, 35 states explicitly prohibit optometrists from performing laser surgery. •••••

Medical Records Notice

••••• BEGINNING JANUARY 1, 1997, providers must inform their patients in writing that their medical records may be released for research purposes and that patients have the right to object. Providers must obtain patients' written general authorization for this kind of release. The general authorizations will not expire unless patients revoke or limit them in writing. Patients may do this at any time.

Providers must note in the medical record when a patient's record is released without the patient's consent for research or any other purpose authorized by law.

The 1996 Minnesota Legisla-

ture passed these provisions in the Omnibus Data Privacy Act as a compromise measure. The MMA and other interested groups had initiated a bill to repeal the June 1996 sunset on a provision allowing medical records to be used for research without the patient's authorization. After much controversy, the sunset was repealed but the requirement to provide written notice was added.

If you have questions about this change in the law, call Patricia Franklin, MMA director of legal affairs, at 612/378-1875 or 800/999-1875.

MMA Presents Stop the Violence Awards

The Minnesota Medical Association presented Stop the Violence Awards to Kathryn C. Halverson, M.D., Sy Vang Mouacheupao, and the Family Violence Network at the MMA Awards Lunch at the Northland Inn in Brooklyn Park as part of the MMA's 143rd Annual Meeting.



Kathryn C. Halverson, M.D., a board-certified family practitioner in Duluth, helped develop the First Witness Child Abuse Resource Center, which coordinates a community response to child abuse in the Duluth area. The program takes a multi-disciplinary approach to the investigation, assessment, medical intervention, and prosecution of child sexual and physical abuse. Halverson, a charter member of the First Witness Board of Directors, headed the medical team, worked with the Duluth regional hospital emergency department staffs, and developed and implemented a three-part curriculum to teach other physicians and nurse practitioners how to evaluate and treat child abuse. Halverson is a staff physician at the Duluth Clinic, St. Mary's Medical Center, St. Luke's Hospital, and Miller-Dwan Medical Center, as well as a clinical instructor in clinical sciences at the University of Minnesota-Duluth School of Medicine.



Sy Vang Mouacheupao has worked as a battered women's advocate within the Twin Cities Hmong community in spite of bitter opposition and even death threats. Placing herself at odds with many people in her community, she has worked tirelessly to inform the Hmong community about laws and customs in the United States and helped to make sure that battered women receive the services they need.

Sy Vang Mouacheupao left Laos in 1976 with her two children and settled in Boston where she studied English and volunteered as an interpreter for Catholic Charities. She moved to Minneapolis in 1980 and worked at Lao Family Community as a Vista volunteer, addressing the needs of Hmong women. Later, she worked for Lutheran Social Services as a caseworker for newly arriving Hmong families and served as a Board member and president of the Women's Association of Hmong and Lao (WAHL). She worked part time for WAHL as an advocate on behalf of battered women until intense pressure from the Hmong community forced WAHL to abandon its advocacy efforts. Sy Vang Mouacheupao then went to work for Community University Health Care Center as an advocate in domestic violence and sexual assault programs. She has played a critical role in providing

direct services to families, educating western professionals about the needs of Hmong families, and providing community education within the Hmong community about the issues of domestic violence and sexual assault.

The Family Violence Network is a private, nonprofit corporation dedicated to eliminating violence in family relationships and promoting self-reliance. Founded in 1981 by four volunteers who were concerned that there was no local agency with the primary responsibility for responding to battered women, the network now provides a wide range of services and programs for individuals, families, children, and communities affected by domestic violence. Network services include a crisis line, emergency transportation, advocacy, women's and children's support groups, assistance in obtaining orders for protection, community education, volunteer training, and safe homes. All services, which are available to Washington and suburban Ramsey County residents, are free and confidential. The network, which originally focused on an immediate response to domestic violence crises, has expanded its programs and services to help victims and families find long-term solutions, encourage self-sufficiency, and improve family relationships. • • • • •

MMA Presents President's Awards

The MMA granted the President's Award to the following MMA members who have made outstanding contributions to the medical profession through their service in the MMA:

- Donald S. Asp, M.D., St. Paul
- Barclay M. Cram, M.D., St. Paul
- E. Duane Engstrom, M.D., Edina
- Erick Reeber, M.D., Bagley
- Richard E. Streu, M.D., Minneapolis

The recipients of the President's Award serve on many committees and volunteer their time and energy to their profession. • • • • •

Survey Shows Greater Awareness of Workplace Violence

More MMA delegates think that yelling, using fear to motivate, and swearing are abusive workplace behaviors today than did three years ago, according to an informal survey conducted at the 1996 MMA Annual Meeting in September.

The survey, developed by the Hennepin Medical Society working with Respond 2, Inc., a private consulting firm, is designed to measure perceptions of abusive and neglectful behaviors in the workplace and home. The confidential survey has been used in more than 40 hospitals, clinics, government organizations, businesses, and universities as the first step in addressing workplace violence.

A. Stuart Hanson, M.D., MMA board member and chair of the Abuse Prevention Project of Hennepin Medical Society, presented the results of the survey at an MMA board meeting in November. "We measured whether there had been any change in attitude among MMA leaders over

the last three years and found that there is greater awareness about abuse today."

In 1993, 6.8 percent of the delegates responding to the survey thought that yelling constituted abuse, while in 1996, 26.5 percent thought so. In 1993, 12 percent thought workplace arguments that got out of control were abusive; in 1996, 25 percent thought so. In 1993, 39 percent considered cursing and swearing abusive; in 1996, 54 percent did.

Who is the most abusive or neglectful?

Physicians were named by 60 percent of the physician delegates. Senior management was listed by 38 percent, and patients or members by 29 percent.

Delegates listed specific examples—a physician swearing at a nurse, a physician berating the nurse when frustrated by a medical problem, a physician verbally abusing office staff

because of a scheduling problem, a senior administrator berating a new employee for asking a question he felt was naive or uninformed, patients threatening staff or swearing at staff.

How often does abuse occur in the medical workplace?

Several times a year, according to 43 percent of the respondents, several times a month according to 16 percent, and once a year according to 14 percent.

Most of the physicians surveyed—74 percent—believe that abuse causes medical problems, such as chronic pain, ulcers, and anxiety. When other groups were surveyed, 85 percent to 95 percent said that abuse causes medical problems.

Most of the delegates—73 percent—think that abuse affects the bottom line. Most believe that abuse could cause or contribute to more sick or vacation days, stress, use of mental health or chemical dependency benefits, use of alcohol, and more visits to the doctor.

Should physician associations such as the MMA be involved with abuse in the workplace?

Seventy-six percent of respondents said associations should be extremely or very involved and 20 percent said they should be somewhat involved.

Hanson invited all physicians to join in an effort to create and promote abuse-free work and home environments. "Just as the medical workplace led the way in creating smoke-free environments, so can the medical workplace lead the way in creating abuse-free environments," Hanson said.

The 5-Stage Process, an organized intervention model developed by the Hennepin Medical Society and Respond 2 Inc., includes education development, guidelines, policies and procedures to prevent abuse and neglect and to promote productivity and health in the workplace. To find out more about the project, call Nancy Bauer at 612/623-2893.

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Conference Helps Communities Respond to Violence

••••• **THE MMA HELPED ORGANIZE** a team of more than 60 Minnesotans to attend the conference, "Family Violence: Building a Coordinated Community Response." The conference, held in Oakbrook, Illinois, October 30 through November 1, was sponsored by the American Medical Association and the American Bar Association along with the U.S. Department of Health and Human Services and the U.S. Department of Justice. Its goal was to help communities develop and implement strategies to reduce family violence.

Teams included physicians,

lawyers, religious leaders, social workers, victim advocates, civic leaders, teachers, and police officers. "This meeting was meant to create a collaborative, multidisciplinary approach to family violence and abuse," said Mark Vukelich, MMA director of communications.

"Family violence can best be addressed by the local community," said Vukelich. "Working together, local physicians, lawyers, social workers, victim advocates, civic leaders, and police can help victims and their families break the cycle of violence."

LEGISLATIVE NEWS

SMOKE-FREE ADVANCES

Duluth passed a strong tobacco ordinance in October that requires single packs of cigarettes to be stored behind the counter. The ordinance passed despite opposition from Brown & Williamson, R.J. Reynolds, and Philip Morris tobacco companies. The ordinance, which will affect 225 tobacco vendors in the city, is being contested by a group of retailers that is trying to collect the 2,987 signatures needed to force the City Council to reconsider the ordinance or put the ordinance up for a citywide vote. The Duluth tobacco control coalition is confident the ordinance will be upheld.

In addition, Golden Valley and St. Louis Park are considering tobacco control ordinances that would ban self-service and require tobacco to be kept behind the counter.

GRASSROOTS GROUP WILL FIGHT LAWSUIT ABUSE

A new citizens group concerned about lawsuit abuse has been formed. The Minnesota Lawsuit Abuse Watch or M-LAW, aims to alert the public about the costs of lawsuit abuse for consumers, businesses, and taxpayers. M-LAW's goals are to expose frivolous lawsuits and to encourage individuals to find out where their legislators stand on reform of Minnesota's civil justice system. MMA member Terence Cahill, M.D., is a member of the board of directors of M-LAW. If you are interested in learning more about M-LAW or joining, call 800/382-0294.

DR. JACOTT ELECTED TO JCAHCO OFFICE

William E. Jacott, M.D., was recently elected vice chair of the Board of Commissioners of the Joint Commission on Accreditation of Health Care Organizations (JCAHCO). He will

assume office January 1, 1997. Jacott, who is an AMA trustee, has served since 1992 as AMA representative to the JCAHCO Board of Commissioners. For the past two years, he has served as secretary of the Board. He will chair the Board of Commissioners beginning January 1999. Jacott is an associate professor and the interim head of the Department of Family Practice and Community Health at the University of Minnesota Medical School.

INDOOR AIR RESOURCES FOR HEALTH PROFESSIONALS

Indoor air can be more seriously polluted than outdoor air in even the largest urban areas, according to the U.S. Environmental Protection Agency. The following resources for health care professionals are available free of charge.

Indoor Air Pollution: An Introduction for Health Professionals

- Provides an overview of indoor air pollutants, symptoms, and suggested remedial action.

- Covers environmental tobacco smoke and other combustion products, biological pollutants, asbestos, lead, sick-building syndrome, and other issues.

- Lists resources for health professionals and patients.

Produced by the U.S. Environmental Protection Agency, the Consumer Product Safety Commission, the American Medical Association, and the American Lung Association.

Radon: A Physician's Guide

- Explains the radon-cancer link, discusses radon testing and mitigation.

- Answers questions about radon, lists resources. (Note: While it is estimated that nationwide one in 15 homes has elevated levels of radon, in Minnesota, health officials

estimate one in three homes is affected.)

Developed by the U.S. Environmental Protection Agency in consultation with the American Medical Association.

Sesame Street Lead Away!

- Uses Sesame Street characters on video and audio tape to teach children habits that will minimize their exposure to lead.
- Print materials provide information about dangers of lead poisoning and preventive measures.

Created by the Children's Television Workshop and the National Safety Council's Environmental Health Center, with funding from the Prudential Foundation.

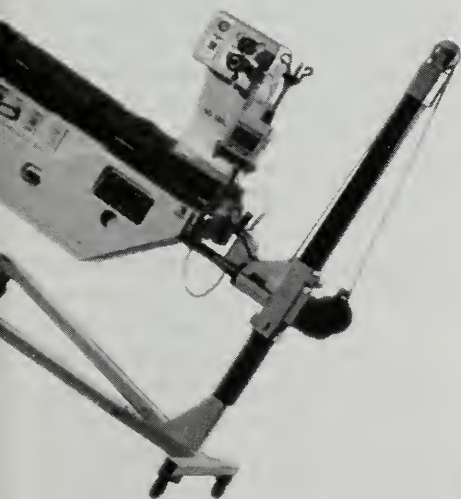
For a single copy of **Indoor Air Pollution or Radon: A Physician's Guide**, or for information on how to order the Sesame Street lead campaign materials, contact Chris Johnson at the Minnesota Safety Council, 800/444-9150 or 612/228-7336.

The Monitor

DECEMBER 1996

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LETTERS

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such as "financial hardship, emotional distress, failure to use contraception properly, [and] less than ideal circumstances" are acceptable indications for an abortion.

I do not believe that physicians possess the wisdom to know better than their patients what is in the patients' best interests. Male physicians may, and often do, empathize with their patients' less-than-ideal circumstances when confronting an unintended gestation. Yet they do not and will never know the serious consequences of an unwanted pregnancy. Physicians will never know the anger many pregnant women feel when their partners abandon them, the pain they experience when they have insufficient funds to properly raise the child, and the fear of raising a child or children alone.

Dr. Struve laments that women seeking abortions are not referred to pro-life counseling agencies. My personal experience with such agencies is that they oftentimes purposely mislead women and give them incorrect and blatantly false information. In addition, pro-life agencies frequently falsify the duration of the gestation, they exaggerate the seriousness and frequency of complications attendant to the abortion, and they claim that the abortion will markedly increase the woman's risk of developing breast and generative tract malignancies. The truth is, the maternal mortality rate for elective first trimester abortion is 0.5 deaths per 100,000 procedures, compared with nine deaths per 100,000 pregnancies for women electing to continue with a gestation.¹

I have a handout entitled "Medical Studies Establish a Connection between Abortion and Cancer in Women" that was given to a patient who was "counseled" at such a pro-choice clinic. The

author states, "I predict that there will be an epidemic of female cancer that will rival the AIDS epidemic." To support his allegation, the author, a Minneapolis attorney, quotes a paper I published about a case of choriocarcinoma discovered at a postabortion examination.² He claims that this malignancy occurred as a consequence of the abortion procedure. What a distortion of the truth!

Dr. Struve states that "most Catholics, Muslims, and many Protestants view abortion as morally wrong." But every major poll conducted in this country substantiates the position that a majority of Americans support *Roe v. Wade*. According to an article in the August 8, 1996, Twin Cities-based *Star Tribune*, a recent study found that Catholic women composed 31.3 percent of the women submitting to an abortion. It is clear that despite the Catholic church's opposition to abortion, Catholic women demand the freedom to make choices about their reproductive lives.

In his article, Dr. Struve demands that society place an "enormously high value on the completion of pregnancy." Who will properly care for these children, many of whom are unwanted, after they are born? Will the members of the so-called pro-life organizations? These organizations are not pro-life but rather pro-birth. They seek to convince all women to continue with every gestation, under all circumstances. After the pregnancy has been successfully concluded, members of these organizations have no further interest in either the mother or her child.

Dr. Struve accepts the need for contraception to reduce the number of unwanted/unintended pregnancies. Yet it is the very people opposed to voluntary pregnancy termination who are vociferously opposed to the use of contraception for all sexually active persons. "Just say no" has certainly

not eliminated or reduced the frequency of illicit drug use. "Just be celibate" will be just as unsuccessful.

With welfare reform, it is reasonable to assume that funds for family planning will soon be curtailed. Are physicians prepared to accept the concomitant rise in unwanted/unintended pregnancy? Will we accept the resultant increase in AFDC entitlements? Currently, one in four unintended gestations end in abortion.³ Among teenagers that rate is undoubtedly higher.

Teenage pregnancy is a disaster for both mother and child. In Minnesota alone, 5,312 teenagers gave birth in 1994.⁴ In the United States, 3 million teenagers each year acquire a sexually transmitted disease, while 1 million of them become pregnant. Seventy percent of births to adolescents occur outside of marriage. Older teenagers and adolescents who are poor or black are more likely to become pregnant than their younger, more advantaged white counterparts. Some 19 percent of all African-American youngsters aged 15 to 19 become pregnant each year, compared with 13 percent of Hispanics and 8 percent of whites. Compared with other countries, teenage pregnancy, abortion, and motherhood are far bigger problems in this country.⁵

The medical profession has not been sufficiently concerned about children becoming mothers. Physicians need to involve themselves in an effort to improve adolescents' lives, not only their health. Unless we do so, we risk losing another entire generation of young people. That we cannot permit.

Fred A. Lyon, M.D.
Obstetrician/Gynecologist
Minneapolis, Minnesota

REFERENCES

1. Lyon FA. Elective termination of pregnancy. In: Benjamin RB, ed. Atlas of outpatient surgery. 2nd ed. Malvern, Pennsylvania: Lea & Febiger, 1994.

2. Lyon FA, Adcock L. Choriocarcinoma presenting as a complication of elective first trimester abortion. *Minn Med* 1980;63(10):733-5.

3. Klein L. Even as new options emerge, gynecologists urge women to find older contraceptives user friendly. *JAMA* 1996;276:6,440.

4. Minnesota Department of Health. 1994 Minnesota health profiles. St. Paul: Minnesota Center for Health Statistics, 1995.

5. Alan Guttmacher Institute. Sex and the American teenager. New York: Alan Guttmacher Institute, 1994.

A Need for Options

I am uncomfortable with and disturbed by the thrust of Dr. James Struve's article, "The Consultation." Let me say that personally and professionally, I have only the greatest respect for Dr. Struve. In fact, he assisted in the delivery, albeit tragic, of my second child, Jacob, who died a day later because of anencephaly.

However, when I read articles like his, strong emotions surface. As a medical student at the University of New Jersey in Newark in the 1960s, I witnessed many septic abortions. The women I cared for were desperately poor blacks and Puerto Ricans who chose a coat hanger as a last resort. Unfortunately, all too many died with sepsis from this tragic attempt at "personal control," as the dedicated Dr. Struve calls therapeutic abortion. The saddest reality, if abortion is actually made illegal, is that individuals with means will *still* be able to obtain an abortion somehow. And the destitute will be the first to suffer the consequences of its prohibition.

I couldn't agree more that abortion is obviously an incorrect form of birth control. A significant number of women who have had abortions have already had at least one abortion and will have another. It is fortunate that in Minnesota, Dr. Mildred Hansen and, administratively, Martha Schultz have helped to make Planned

Parenthood available as a fear-free option.

I struggle with Dr. Struve's statement, "All faiths need to continue to expound on the value God places on life," especially when individuals would have us believe that one person's life is any more important than another. If the poor are denied access to abortion, there is every likelihood that what I saw in the 1960s will recur. Likewise, the consequences of unwanted or doomed pregnancies makes me question who has a right to determine what is or is not godly.

*Peter J. Dorsen, M.D.
General Medicine/Writer
Minneapolis, Minnesota*

Dr. Struve Responds

I appreciate the comments of each respondent who took the time to reply to my article, "The Consultation," published in the August 1996 *Minnesota Medicine*.

My article was meant to communicate how difficult it is for me to recommend an abortion for psychosocial indications, as compelling as they often are. As Dr. Hodgson points out, I must be fair to my patients and the choices they make and have been given legally. I feel I also must be free to express my view on the appropriateness of a medical procedure when I feel it may not be in the patient's and her pregnancy's best interest. Is this being paternalistic or just being a good physician? I agree with Dr. Howard when he states that indications for abortion are not normally indications to perform any other elective procedure.

I should hope my 21 years of experience in primary care medicine were all brought to bear on the manner in which I made my recommendation, without devaluing the patient or ignoring her request. Those of us in primary care all have experience and expertise in making recommendations that run counter to patient

expectations (e.g., the patient who wants an MRI for a sore knee). We physicians can differ in our recommendations. A second opinion is not more than a day away and seldom a clinic away.

My article was not about "recriminalizing abortion" or about "compulsory pregnancy" or about trivializing what is at stake for the woman and her family. It was not about making a political statement. It was not about the compelling issue brought up by Dr. Lyon of support for the unloved, unsupported infant. If my statements seemed like playing God, as my good friend Peter Dorsen suggests, then he knows more about God's will than I do when I introduce myself to a woman with an unwanted pregnancy.

My issue is with the prevailing indications for an abortion and the processes in place that rightly bestow high value on freedom of choice but, I think, wrongly allow that freedom as license to terminate created human life for reasons less than tragic. My article is about doing justice for both women and their pregnancies—balancing the freedom to choose and the principle of reverence for human life that undergird the Constitution of this country and the principles and practice of medicine.

My call is for each major integrated health network to develop a hospice-like case-management system, an immediate resource independent from abortion providers. Personnel at these centers would assess the patient's situation, link up with resources to preserve the pregnancy if possible, correct whatever misinformation is being promulgated about abortion, refer for abortion only if all other options fail, and afford grief follow-up and linkage back to primary care.

*James K. Struve, M.D.
Family Physician
Minneapolis, Minnesota*

PLOTNIKOFF

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As an undergraduate at Carleton College in Northfield, Minnesota, he wrote a paper, "Caring Services: My Response to Human Value," for an essay contest. As the sole undergraduate winner, Plotnikoff was selected to attend the First International Conference on Human Values in London. There he met his hero and mentor, ordained minister Howard Bell, who at the time ran the hospice program at Abbott Northwestern Hospital in Minneapolis. Plotnikoff began volunteering his Friday evenings at the hospice.

Plotnikoff and Bell have maintained a personal and professional friendship to this day. "Greg has brought a humaneness, a caring, and his own spirituality to bear on his work," says Bell, who is now director of Pathways, a health crisis re-

source center in Minneapolis. "He is a unique doctor and teacher."

During undergraduate school, Plotnikoff also studied social and political philosophy. He realized that in order to critique social policy, he needed a context against which to judge it. So he went to Harvard Divinity School, where he earned a master of theological studies in 1985. He then went on to medical school and his residency at the University of Minnesota.

Trained as chaplain and physician, Plotnikoff questions assumptions about medical education. "Medical students are taught to always be active, always be doing something," he says. "You learn that you're there to provide the answers for the patient."

What's missing, according to Plotnikoff, is learning how to just "be" with the patient and to listen. "In two minutes of uninterrupted speech, a patient can tell you quite a

lot. But most doctors interrupt after 18 seconds," he adds.

"Medical students are taught to be problem solvers, to be hypothesis-driven," he continues. Such a mindset leads only to questions that discourage conversation. As a result, physicians risk missing what patients have to say about their illness.

"Disease and illness are not the same," says Plotnikoff. "Disease is aberrant physiology, whereas illness is what the patient experiences, the meaning he or she ascribes to the disease." Nowhere is this more evident than in the way other cultures respond to disease. These differences are often noticeable through the window of language. "For instance, the Hmong have no word for 'diabetes,'" he adds.

Studying the languages of the people he cares for at the Community-University Health Care Center is one way Plotnikoff connects with his patients. He is learning Vietnamese and Hmong but explains the difficul-



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ty he faces. Both are tonal languages, and Plotnikoff is tone deaf. He admits he sometimes asks patients if their "rice," rather than their "pain," is feeling better. "At least it's a good ice-breaker," he adds with a grin.

Plotnikoff credits Frank Cerra, M.D., provost for the University of Minnesota Academic Health Center (AHC), for providing a strong leadership role in connecting spirituality and health care. Cerra says, "We are just beginning to understand the role health care providers have in promoting health or wellness and how these interact with disease and the treatment of disease."

Cerra has appointed Plotnikoff and Kreitzer to head the Academic Health Center Task Force on Complementary and Integrative Care. The task force has adopted a listening posture, meeting throughout the fall with the complementary care community, metro area health providers, and other interested constituents. In January 1997, Plotnikoff and Kreitzer will articulate the task force's vision and direction for the education, research, and service components of complementary care for the AHC.

Plotnikoff's hectic schedule includes several other professional responsibilities. He is an associate of the University of Minnesota Center for Biomedical Ethics; cochair of the Interdisciplinary Pain Management Task Force at the University Hospital; physician representative to the University Hospital Bioethics Committee; and board member of the Community-University Partnership for Education and Service.

How does Plotnikoff juggle all the demands on his time? He practices what he preaches, paying attention to body, mind, and spirit. He swims and is an avid kayaker. He is currently taking a meditation class and, on occasion, preaches at local churches. "I pursue my spirituality through prayer, meditation, and reading," he says.

Plotnikoff realizes integrating spirituality with medicine is no easy task. "You must first confront the issue of spirituality for yourself," he says. "Like sexuality and death, spir-

ituality is not something people are comfortable with. The greatest challenge may be to explain to students that it can't be taught, that one has to look inside oneself for the answers.

"Medicine is an art," he con-

cludes. "If you understand the patient's story, then you can help him or her write the next chapter." MM

Deborah Sugerman is a free-lance writer residing in Minneapolis.

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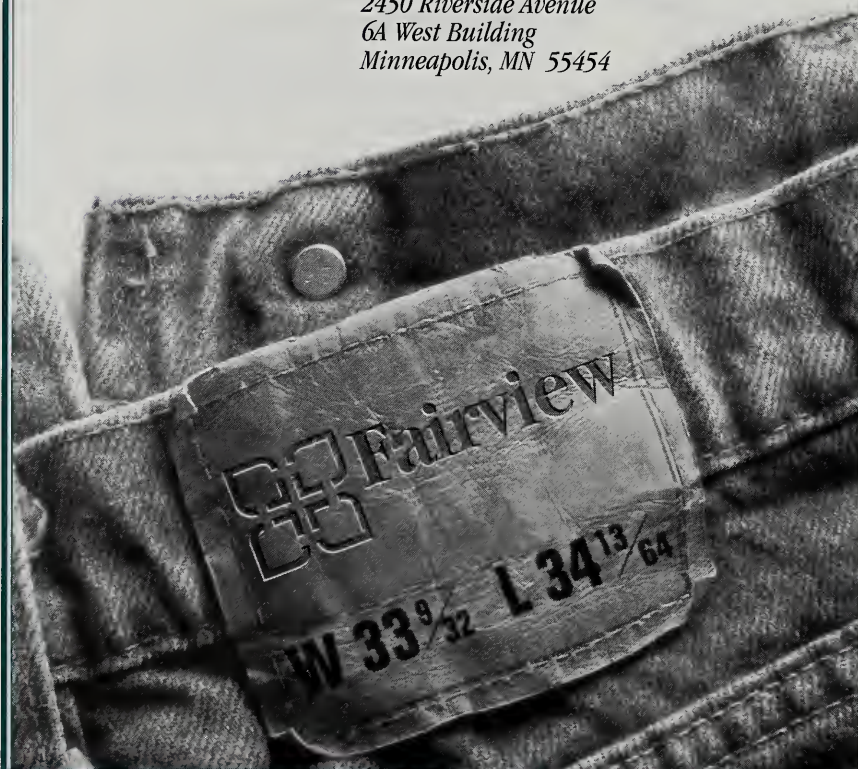
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HEALING JOURNEY

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I also reap the rewards of a lifetime investing in quality friendships and relationships. I believe that at the end of our lives, all that really matters is whom we loved and who loved us. Finding ways to share myself with others has its own healing effect. And through their love and support, my husband and two sons contribute greatly to my well-being.

For my spirit, I try to comprehend my existence on a level beyond my physical body. I have learned to live more fully in the moment and not to wish time away. I pay more reflective attention to my sense of purpose in life. Feeding my spirit is prayer, my connection with a church community, and spiritual work that is not directly church related. I've been in a women's spiritual growth group for 18 years and in a couples' group with my husband for nearly as long.

My healing journey has been close to ideal. Life will never be the same as before, and adjusting constructively to that reality has been an internal process—not just a matter of finding the right combination of acupuncture and herbs. Being the point person for my own healing allows me to feel in control of my life, in spite of cancer.

I am generally impressed with the quality of care in the complementary realm and have found those practitioners more emotionally and physically accessible than most physicians I have consulted in recent years. Drawing from my experiences, I offer a few thoughts to the medical community.

• I believe that true healing cannot be separated from its spiritual foundation. Physicians need to be interested in the quality of their patients' spiritual and emotional lives, as well as in their medical histories, and they need to be open-minded about the impact of religious belief and spiritual practices on healing. Being able to hear a patient's deepest

fears about dying requires a high degree of spiritual maturity, and it is the rare physician who can be present in such a way.

• The medical community needs to reconceptualize death, not as the enemy but as the natural conclusion of our earthly journey. Patients sense their doctors' feelings about death and can feel like failures if they aren't cured. The focus of medicine should be on healing, not curing. If a cure happens, wonderful. But medicine's focus should be helping patients learn to live quality, relatively comfortable lives despite illness, or helping them heal into death.

• I would like to see more partnerships and collaboration in medicine—between medical institutions and their communities, between patients and physicians, and between medical doctors and other practitioners involved in patient care. We need more respect and less professional antagonism, arrogance, and hegemony in the field. I envision a completely integrated wellness or healing model.

• Medical students should be more deliberately selected for their potential as healers as much as for their intellectual ability. During their training, they should be treated as valuable resources, given the same respect they are to show future patients. Medical students should be exposed to a full range of complementary modalities and encouraged to grow as human beings, not just as technicians or mechanics.

A new era in medicine is at hand—one that will end the false divisions between body, heart, mind, and spirit. Most doctors I know went into medicine with the notion—and the ideal—of becoming healers. They, too, are longing for something more spiritually rewarding from the human connections in medicine. **MM**

Penny George is a founding partner in Sellergren-George Consulting Psychologists. Her article is excerpted from October 1996 testimony to the University of Minnesota's Academic Health Center Task Force on Complementary and Integrative Medicine.



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People and Places Making Medical News

P e o p l e

American Cancer Society Medal of Honor

B.J. Kennedy, M.D., retired University of Minnesota Regents' Professor of Medicine, was one of three people to receive the American Cancer Society's Medal of Honor at the organization's annual meeting November 3. Kennedy, considered the "father of medical oncology," received the award for his pioneering efforts in establishing medical oncology as a subspecialty of internal medicine. He was also recognized for his groundbreaking research in improving treatment for breast, testicular, and endometrial cancer, along with leukemia, lymphoma, and Hodgkin disease.

Kennedy began his career in medicine and oncology in Minnesota in 1951. He served for 23 years as director of the division of oncology within the University of Minnesota's Department of Medicine.

HealthPartners Appointments

Six physicians have been named to new positions within HealthPartners Medical Group.

William Ganz, M.D., has been named neurosurgery department chair; Erhard Haus, M.D., pathology department chair; Steven Koop, M.D., orthopedics department chair; and Larry Boies, M.D., otolaryngology department chair. They will be responsible for providing leadership in planning, program development, quality assurance, physician recruitment, performance evaluations, medical credentialing, and medical education and research in their respective departments.

Debra Johnson, M.D., has been named pediatric and adolescent

medicine department head, and Bill Litchy, M.D., neurology department head.

Neighborhood Health Care Network Medical Director

C. Carlyle Clawson, M.D., a professor of pediatrics at the University of Minnesota Medical School and staff member at the University of Minnesota Hospital and Clinic, has been named medical director of the Neighborhood Health Care Network (NHCN), a management services organization for Twin Cities area community clinics. NHCN was formed in 1995, and its 17 member clinics serve about 100,000 patients a year.

Clawson will direct program expansion initiatives and policy and procedures development, oversee clinical chart review activities, and participate in outcome measurement activities.

HealthSystem Minnesota Senior Vice President

Richard B. Freese, M.D., has been named senior vice president for clinic services at HealthSystem Minnesota. In this newly created position, Freese will coordinate operations at Park Nicollet Clinic, a multispecialty group with approximately 400 physicians practicing in 19 locations throughout the west metro area of the Twin Cities. Freese, who specializes in internal medicine, joined Park Nicollet Clinic in 1990.

Medical Alley Board Members and Officers

Medical Alley, the St. Louis Park-based trade association for Minnesota's health care industry, elected

new board members and officers at its annual meeting October 28.

Newly elected board members include Craig Howe, M.D., chief executive officer, National Marrow Donor Program; Lisa Olson, Ph.D., vice president, corporate marketing and planning, Summit Medical Systems; Ann Schrader, group vice president, patient care delivery, HealthEast; Mark Skubic, vice president, public policy and government relations, HealthSystem Minnesota; and Gervaise Wilhelm, president and chief executive officer, Interventional Innovations Corp.

The following officers were also elected: chair of the board, James B. Dixon, president and chief executive officer, HealthPartners/St. Paul-Ramsey Medical Center; first vice chair, Marlene Travis, president and chief operating officer, Health Risk Management, Inc.; second vice chair, Jerry Haarmann, chief executive officer, Memorial Blood Centers of Minnesota; third vice chair, Marcus Merz, president and chief executive officer, Preferred One Management Corp.; treasurer, James Ravell, partner, Grant Thornton LLP; counsel, Margo Struthers, partner, Oppenheimer Wolff & Donnelly; secretary, Delwin Ohrt, M.D., senior vice president and medical director, Blue Cross Blue Shield of Minnesota; and president, Thomas Meskan, Medical Alley.

P l a c e s

UCare Minnesota Wins Award for Immunization Program

UCare Minnesota, a St. Paul-based HMO created specifically to serve low-income individuals, has received an American Association of Health Plans Celebrating

Innovation Award for its outstanding childhood immunization program.

UCare developed its Childhood Immunization Incentive Program in 1992 with a start-up grant from the Minnesota Department of Human Services. The program offers parents gift certificates for use at a local grocery store when their children receive immunizations. UCare pairs the incentive program with a county-based community health visiting program, in which a public health nurse visits with parents to discuss preventive care.

UCare immunization rates have risen from 46 percent in 1991 to 79 percent in 1994. The HMO's goal is to achieve 90 percent immunization for 2-year-olds by the year 2000.

Allina Considers Alternative Therapies

Allina Health System is considering offering and covering alternative and holistic therapies following a survey showing consumer demand. Two-thirds of 400 households surveyed included at least one person who had used some type of alternative therapy during the past two years. Three-fourths of those surveyed said they would be at least somewhat likely to use an alternative therapy for a health problem that traditional medicine cannot effectively treat.

Richard Sturgeon, M.D., a vice president of Allina Health System, said in a Twin Cities-based *Star Tribune* article, "We need research to identify complementary therapies that are effective and find ways to apply them to our patients." Sturgeon indicated Allina would try to combine complementary and conventional therapies. He also added that some of the complementary therapies might lower health care spending.

Socioeconomics

HMOs Buoyed by State-Supported Programs

Minnesota HMOs earned \$26.8 million from state-supported health care programs in 1995, according to Minnesota Managed Care Review 1996, an annual report on the industry prepared by consultant Allan Baumgarten.

Baumgarten also reported that premium increases for the state's employers and their workers dropped 0.6 percent, the first decline in the rate of increase since 1990. "It's a sign that in order to maintain market share, HMOs essentially held premiums flat in 1995," said Baumgarten in a *City Business* article. "During 1996 there was some indication that this was starting to break up. Quotations are in the 3 to 6 percent [increase] range for employer groups," he added.

HMOs lost \$3.2 million on their operations in 1995, according to the report, but relied on investment income of \$56.3 million to end the year with a positive bottom line. While commercial enrollment grew by 8.1 percent, HMO enrollment margins decreased 2.3 percent, their lowest level since 1989.

The report also indicated that in 1995, the number of Minnesota workers whose employers finance their own health care increased by about 200,000.

Consumer Survey Measures Patient Satisfaction Levels

The Buyers' Health Care Action Group released the first consumer satisfaction survey in Minnesota, ranking 21 large care systems on a variety of factors, including how long patients have to wait to see physicians and the amount of time physicians spend with members and their children. Results showed that the most expensive primary care clinics don't always have the most satisfied customers. Two groups—Hennepin Faculty Associ-

ates and a group of clinics affiliated with Allina's Abbott Northwestern Hospital—rated high in patient satisfaction and were among the least costly providers in the metro area.

Formed in 1991, the buyers' action group represents 25 of the state's largest companies. The group hopes the survey will help the companies' employees make more informed choices and encourage health care providers to be more accountable for cost and quality. Results of the survey are available through the Internet at <http://www.consumerchoice.com>

Researchers Call for Paying Physicians More for Sicker Patients

A research team from Minnesota and Maryland recommends that health plans pay physicians more for treating sicker patients, according to a report published in the October 23 *Journal of the American Medical Association*. The increasingly used capitated fee system discourages doctors from treating ill patients and from providing expensive diagnostic tests and therapies. "If a doctor sees too many sick patients, he will go broke under the present payment system," said Jinnett Fowles, the lead author of the study, in a Twin Cities-based *Star Tribune* article.

Fowles, a health care researcher at HealthSystem Minnesota's Institute for Research and Education, conducted the research with Jonathan Weiner, a professor of health policy and management at the Johns Hopkins School of Public Health. They propose basing payment on risk so physicians, clinics, and other health care providers are paid according to how much care their enrollees are likely to need. Risk would be measured by the physicians' diagnoses.

The Buyers' Health Care Action Group plans to use the new

payment system beginning January 1, 1997, in contracting with 16 health care delivery systems.

Enforcing Ban on Tobacco Sales to Minors Proves Effective

Communities that have aggressively enforced the ban on sales of tobacco to minors are twice as effective in getting stores to comply with the law, according to a study by the Minnesota Attorney General's Office. Communities that have enjoyed these results include St. Paul, White Bear Lake, Fergus Falls, and Savage. The study also noted a far higher overall rate of compliance compared with the results of a similar survey in 1994.

Minnesota also participated in a five-state sting operation that found that one in three teenagers was able to buy cigarettes. Discount stores were the easiest place for minors to purchase cigarettes.

Allina, Medica Cutting Costs

Allina Health System has initiated a plan to cut administrative costs at its Minnetonka headquarters and to reduce medical and other expenses at the Allina Medical Group and Medica, its health plan. With a total operating budget of more than \$2 billion, the company is not expected to lose money in 1996. However, it might not achieve a 3 percent operating margin, the organization's goal for the year, according to John Grotting, vice president for care delivery operations. Grotting attributed this to rising medical costs coupled with competitive pressure to maintain stable premiums.

As part of the effort to reduce Allina's administrative costs by 15 percent, the company offered voluntary severance packages to 2,000 employees at its central finance, legal, human resources, and other corporate service departments. Company spokesperson Sarah Stoesz said the number of

layoffs would probably be significantly smaller because severances will be available only to those whose jobs could be permanently eliminated.

The Allina Medical Group has canceled or delayed construction and expansion plans and is looking for ways its doctors and staff can be more efficient.

Medica hopes to cut costs by \$37 million in 1997. To meet its goal, Medica plans to lower fees paid to hospitals and physicians—especially specialist physicians—and to initiate new cost-control efforts on pharmaceutical drugs and radiology and laboratory procedures. David Strand, Medica president, said in a Twin Cities-based *Star Tribune* article that with drug costs increasing nearly 15 percent each year, pharmaceuticals are the fastest rising category of health care costs today.

St. Jude Purchases Three Medical Technology Companies

Little Canada-based St. Jude Medical, the world's largest maker of heart valves, has announced the purchase of Ventritex Inc., Teletronics Pacing Systems, and Medtel. Ventritex of Sunnyvale, California, makes implantable cardiac defibrillators. Teletronics, located in Englewood, Colorado, makes the wires that connect the defibrillators to the heart. Medtel is a medical products distribution business in the Pacific Rim.

All three operations will remain in their current locations, and St. Jude has no plans to add or eliminate any jobs in the immediate future as a result of the acquisitions, said company spokesperson Peter Gove in a *St. Paul Pioneer Press* article.

Medigap Insurance Premiums Increase Sharply

Medigap insurance premiums have increased anywhere from 20 percent to 40 percent, reports Families USA, a consumer advocacy group on health care issues.

About three-fourths of senior citizens have a Medigap policy to cover health care costs that Medicare won't pay, such as deductibles and prescription drugs.

Families USA analyzed premium increases between 1995 and 1996 for Prudential and Blue Cross Blue Shield, the two companies that underwrite more than half of the nation's \$12 billion Medigap market. Prudential, with the largest Medigap sales, had premium increases in the states surveyed averaging 23 percent, or nine times more than Social Security benefits rose. Premiums for Blue Cross Blue Shield increased less than Prudential's, but often still outpaced Medicare inflation or Social Security cost-of-living adjustments.

InterStudy Releases HMO Industry Report

National managed care firms accounted for 81.8 percent of total U.S. HMO enrollment and 68 percent of total HMO enrollment growth in the six months ending January 1, 1996, according to InterStudy's Competitive Edge Industry Report 6.2.

Other highlights from the report state that the proportion of HMOs reporting positive profit margins decreased significantly from 88 percent in 1994 to 61 percent in 1995. HMOs reporting losses in operating margin increased from 13 percent in 1994 to 40 percent in 1995.

Average monthly commercial HMO premiums for families in 1995 were \$384 for a traditional plan and \$389 for an open-ended plan. Average monthly commercial HMO premiums for individual coverage were \$140 for a traditional plan and \$147 for an open-ended plan.

As of January 1, 1996, almost one-third of commercial HMOs reported offering HMO enrollment to Medicare beneficiaries, and more than one-third offered a

Medicaid product. HMO Medicaid enrollment grew 33.2 percent in 1995.

Rates, Trends, Data

Number of HIV-Infected Pregnant Women Higher than Reported

The Minnesota Department of Health has reported that 24 women in Minnesota were infected with the AIDS virus when they gave birth in 1995. Blood samples taken from newborns to detect treatable abnormalities were used to test for HIV infection, and any information that would identify the mother was removed from the samples to protect the mothers' privacy. The health department received reports of only 16 cases of pregnant women with HIV last year, suggesting that the other eight women are likely unaware that they are HIV-infected.

Richard Danila, Ph.D., an epidemiologist with the department, said most of Minnesota's more than 5,000 cases of HIV infection and AIDS have occurred among residents of Hennepin County, and the rate of infection has been much higher among blacks than whites. Of the 24 pregnant women who were HIV positive, 22 lived in the Twin Cities and 12 were black.

The health department, the U.S. Centers for Disease Control and Prevention, and the Minnesota Medical Association advocate HIV counseling and voluntary testing for all pregnant women.

Chlamydia Is Most Common Infectious Disease

The Centers for Disease Control and Prevention (CDC) has reported that chlamydia was the most common infectious disease for 1995. Gonorrhea and AIDS were second and third on the list. These three, plus syphilis and hepatitis B, accounted for 87 percent of the

total number of cases caused by the top 10 maladies, according to the CDC report.

In 1995, there were 477,638 reported cases of chlamydia, a parasitic infection that often has no symptoms but, if not treated with antibiotics, can lead to infertility and tubal pregnancies. This is the first year the infection was included in the national report.

Medical Research

Study Links Healthy Bones With Breast Cancer

Women with the thickest and presumably healthiest bones had a 50 percent greater risk of developing breast cancer than women with the thinnest bones in a study of 6,800 women, 2,460 of them in Minnesota. The study results are reported in the November 11 *Journal of the American Medical Association*.

"Women with higher bone density have a higher risk of breast cancer, and women with lower bone density have a higher risk of fractures," said Kristine Ensrud, M.D., a University of Minnesota researcher and principal investigator for the study, in a Twin Cities-based *Star Tribune* article.

According to Jane Cauley, M.D., a researcher at the University of Pittsburgh and the lead author of the report, the study is the first to link strong, healthy bones and breast cancer. She indicated that identifying a common denominator for healthy bones and breast cancer should substantially improve understanding of cause and prevention. Ensrud added that internally produced estrogen could be responsible for both conditions.

Early Surgery Improves Mortality of Patients With Heart Defect

Patients who underwent surgery to correct leaky mitral valves lived longer than those treated with drugs in a first-ever Mayo Clinic

study published in the November 7 *New England Journal of Medicine*.

An estimated 1 million Americans, most in their 60s and 70s, have a severe form of mitral regurgitation due to flail leaflet. Physicians have debated which treatment—surgery or medication—is best, since no data has existed showing how well patients did after surgery. The Mayo Clinic study collected clinical follow-up data in 1994 and 1995 on 229 patients who had been diagnosed with flail leaflets between 1980 and 1989.

Investigators found that 30 percent of the 86 patients treated medically developed atrial fibrillation, 63 percent developed heart failure, and 80 percent required surgery over a 10-year period. "We found that 90 percent of the patients treated medically were either dead or had surgery within 10 years of the diagnosis," said Maurice Enriquez-Sarano, M.D., consultant in cardiovascular diseases and associate professor of medicine at the Mayo Clinic, in a *St. Paul Pioneer Press* article. The 143 patients who underwent surgery had reduced mortality rates.

Because surgery is virtually inevitable, he said, patients should consider it as soon as possible to eliminate the overload and preserve the heart muscle.

'U' Develops Way to Track AIDS Virus

University of Minnesota researchers have devised a way to visualize and count HIV virus particles in two compartments of the immune system: on the surfaces of cells that store the virus and in the interiors of cells that produce new virus particles. The technique will allow researchers and clinicians to follow changing patterns of production and distribution of the virus within immune cells during the course of infection and could lead to a tool

for monitoring the efficacy of therapies. Results of their research were published in the November 8 issue of *Science*.

Working with tonsil biopsies from HIV-infected patients, University of Minnesota microbiologist **Ashley Haase, M.D.**, and colleagues used a combination of techniques to count viral particles within the immune cells that produce them—collectively called mononuclear cells (MNCs)—and attached to the outer surfaces of follicular dendritic cells (FDCs), which are part of the cellular structure of tonsils. Because numbers and proportions of virus found in these two locations may vary during infection or treatment, monitoring these changes should give a much better picture of what actually goes on during HIV infection than does measuring amounts of virus in the blood-stream—the current method of following an infection and monitoring the effects of treatments.

The ability to localize and count the virus may be used to answer many questions, Haase said. For example, a regiment of three drugs can clear the blood-stream of detectable virus in a few weeks, but such a result says nothing about what might be going on in tonsils, lymph nodes, and other lymphoid tissues.

Patient Care May Benefit When Physicians, Nurses Collaborate

Patient care may benefit from improved ethical decision-making when physicians and nurses communicate more effectively, according to researchers at Abbott Northwestern Hospital. The study focused on decision-making surrounding appropriate levels of care for ICU patients. Results showed that the perception of who is involved in making patient care

decisions depends on who is asked. Nurses saw themselves as having a much more active role than physicians perceived. At the same time, physicians saw themselves as taking a more active role in communicating decisions with patients than nurses perceived.

“The pace of technology in ICU is moving much faster than our ability to talk about the decisions we’re making,” said **Deborah Rudquist, R.N.**, a principal investigator for the study. “We wanted our research to tell us how to improve communications between doctors and nurses because it’s so important to the health of our patients.”

Bedrails Present Risk to Frail People

Several thousand people suffocate every year in nursing homes when they become wedged against ill-fitting mattresses or tangled in bedrails, according to a study by **Steven Miles, M.D.**, a medical ethicist at the University of Minnesota who practices geriatric medicine at St. Paul-Ramsey Medical Center. Most of the deaths happen at night and involve people who are frail or confused or who have been given sedatives or other drugs. Most of the victims in the study were women over age 70. Such deaths are underreported to state and federal officials who oversee health care facilities, said Miles in a Twin Cities-based *Star Tribune* article.

Miles reported his study results at a state meeting of nursing home medical directors. He said that nursing home and hospital staffs need to carefully evaluate a person’s condition before using bedrails. He also called for standardized designs for bed components now manufactured by more than 100 firms.

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A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

JANUARY 1997

Jan. 20-24 **Challenges in Hematology and Hematopathology** Mayo Medical Laboratories; Silvertree Hotel, Snowmass, CO. CONTACT: Kathy Bates, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

FEBRUARY 1997

Feb. 6-8 **Twenty-second Annual Winter CME** Minnesota Academy of Physician Assistants and Wisconsin Academy of Physician Assistants; Holiday Inn, Duluth, MN. CONTACT: Cindy Ulshafer, 1825 Center Street, Centerville, MN 55038-9779; 612/653-4736.

Feb. 10-17 **HealthEast 1997 Winter Medical Seminar** HealthEast St. Joseph's Hospital; The Melia Playa Conchal Beach and Golf Resort, Costa Rica. CONTACT: Annette Anderson, 1700 University Avenue West, St. Paul, MN 55104; 612/232-5104.

Feb. 15-19 **Selected Topics in Internal Medicine** Mayo Foundation; Rancho Bernardo Inn and Resort, San Diego, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MARCH 1997

Mar. 1-8 **Ramsey Medical Society Winter CME Conference** Ramsey Medical Society; Sheraton Resort, Xtapa, Mexico. CONTACT: Jennifer Stendahl, Ramsey Medical Society, PO Box 131690, St. Paul, MN 55113; 612/362-3701.

Mar. 14-15 **Current Issues in Cancer Prevention, Detection, and Treatment** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MAY 1997

May 6-9 **Fourth International Surgical Pathology Symposium** Mayo Medical Laboratories; Hotel Estoril Sol, Cascais, Portugal. CONTACT: Kathy Bates, Mayo Medical Laboratories, Office of Continuing Education, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

Videotapes: **Emerging Infectious Diseases** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Physician Cancer Support Group

A year ago, a peer support group for physicians with cancer was formed by the Hennepin Medical Society at the Virginia Piper Cancer Institute. Regular monthly meetings started in August to provide a setting in which physicians could exchange concern and feelings on the challenges unique to those in their profession with cancer. About 25 physicians and spouses have attended one or more session.

There is no charge for the group.

The group meets:

Second Thursday of each month
7 pm to 8 pm

Virginia Piper Cancer Institute
800 East 28th Street at Chicago Avenue
Minneapolis, Minnesota

If you have any questions about the group, contact Dick Sellers, facilitator, at 612/863-4000.

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97 Jeep Grand Cherokee Laredo	\$28,188	\$26,149	\$444	\$373	\$341	\$303
96 Nissan Pathfinder SE	\$30,618	\$28,568	\$450	\$393	\$362	\$334
97 GMC Yukon SLE 4dr	\$32,999	\$31,327	\$464	\$414	\$391	\$362
97 Chevrolet Tahoe LS 4dr	\$32,935	\$31,270	\$464	\$413	\$391	\$362
97 Chevrolet Suburban 1/2 LS	\$36,457	\$34,293	\$541	\$476	\$446	\$420
97 Toyota 4-Runner SR5 4dr	\$31,953	\$30,540	\$494	\$413	\$371	\$342
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- Cancellation of ads must be made by the first of the month preceding month of issue.

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

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Fergus Falls Medical Group is expanding its 30-physician multispecialty clinic and is seeking physicians in the following specialties: dermatology, family practice, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (8/96-R)

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Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

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